State of Hawaii
Department of Public Safety

PANDEMIC RESPONSE PLAN
COVID-19

(August 03, 2021 Revision)

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Pandemic Response Plan Overview

The COVID-19 Pandemic Response Plan was developed by VitalCore Health Strategies and approved by Lannette Linthicum, M.D., and the Office of Correctional Health of the American Correctional Association (ACA). The Department of Public Safety reviewed the plan, which is based upon current guidance from the CDC, and adapted the plan for Hawaii's correctional system. The CDC Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities and FAQs for Correctional and Detention Facilities provide additional detailed guidance. It is anticipated that the CDC guidance will continue to change so the plan will require revision accordingly.

COVID-19 presents unique challenges for prevention and containment in the correctional environment. Knowledge about COVID-19 and public health guidance for responding to the Pandemic is rapidly changing. Adaptable and updatable practical tools are needed to develop infection prevention and control plans for COVID-19 across a diverse array of U.S. jails and prisons.

The COVID-19 Pandemic Response Plan provides an outline of infection prevention and control information that should be considered for correctional facilities related to a COVID-19 response. The plan provides supplemental guidance to the previously distributed Infectious Disease Clinical Care Guide and existing policies. The plan outline is paired with a fillable MS WORD® Implementation Worksheet that can be customized to address facility-specific issues of concern.

The 1918-19 influenza pandemic provides important lessons for responding to COVID-19. During the 1918–19 influenza ("flu") pandemic, certain cities fared better than others. Those U.S. cities that both acted promptly to control the flu and implemented multiple layers of protective measures had fewer flu cases and lower overall mortality. The COVID-19 Pandemic Response Plan includes multiple layers of protective measures to minimize the impact of the virus in the correctional environment.

The Pandemic Response Plan includes 15 response elements. Each element is outlined in the plan with a corresponding section of the Implementation Worksheet. When completing the Worksheet, it is recommended to reference the corresponding text in the Pandemic Response Plan. The Worksheet can be readily adapted to meet the unique challenges of a specific facility. The CDC COVID-19 Management Assessment and Response Tool (CMAR) for Correctional and Detention Facilities may also be used to facilitate communication between the Department of Health and correctional facilities of the Department of Public Safety in preparation for introduction, transmission, and mitigation of COVID-19 in correctional facilities.

Effective response to the extraordinary challenge of COVID-19 requires that all disciplines in a correctional facility work collaboratively to develop, modify, and implement plans as information and conditions change. Swift, decisive, yet evidenced-based planning is paramount. The intent of this document is to advance our collective efforts to better ensure the health and safety of our correctional employees and our incarcerated population.

COVID-19 Overview

The Department of Public Safety is closely monitoring the spread of the novel coronavirus 2019 (COVID-19). Current information provided by the Center for Disease Control and Prevention (CDC) is included below.

What is Coronavirus Disease 2019 (COVID-19)?
Coronavirus Disease 2019 (COVID-19) is a respiratory illness that can spread from person-to-person. The virus that causes COVID-19 is a Novel Coronavirus that was first identified during an investigation into an outbreak in Wuhan, China and is now causing an International pandemic.

How is the virus causing COVID-19 transmitted?
The virus is thought to spread mainly between people who are in close contact with one another (within approximately 6 feet) through respiratory droplets or small particles produced when an infected person coughs, sneezes, breathes, sings, or talks. Under certain circumstances (e.g., when people are in enclosed spaces with poor ventilation), COVID-19 can sometimes spread by airborne transmission. COVID-19 spreads less commonly through contact with contaminated surfaces (i.e., by touching a surface or object that has the virus, and then touching the mouth, nose, or eyes). The virus is spreading very easily and sustainably between people. In general, the more closely a person interacts with others and the longer that interaction, the higher the risk of COVID-19 spread.

What are the symptoms of COVID-19?
People with COVID-19 have had a wide range of symptoms reported – ranging from mild symptoms to severe illness. People with the following symptoms may have COVID-19 (not all possible symptoms are listed):

- Fever or Chills
- Cough
- Shortness of Breath or Difficulty Breathing
- Fatigue
- Myalgia, Muscle or Body Aches
- Headache
- New Loss of Taste (ageusia) or Smell (anosmia)
- Sore throat
- Congestion or Runny Nose (Rhinorrhea)
- Nausea or Vomiting
- Diarrhea or Loose Stool

Emergency warning signs for COVID-19 include:

- Trouble Breathing
- Persistent Pain or Pressure in the Chest
- New Confusion
- Inability to Wake or Stay Awake
- Pale, gray, or blue-colored skin, lips, or nail beds, depending on skin tone

Seek emergency medical care immediately if someone is showing emergency warning signs. The list of emergency warning signs is not exhaustive. Contact medical if any other symptoms are severe or concerning. Complications of COVID-19 can include pneumonia, multi-organ failure, and in some cases death.

How can I help protect myself?
People can help protect themselves from respiratory illness with everyday preventive actions.

- Wear a mask. Cover your mouth and nose with a mask when around others.
- Avoid close contact with people who are sick and people who do not live in your household; maintain good social distancing (about 6 feet).
- Get vaccinated.
- Avoid crowded indoor spaces and ensure indoor spaces are properly ventilated by bringing in outdoor air as much as possible.
- Wash your hands often with soap and water for at least 20 seconds.
- Use an alcohol-based hand sanitizer that contains at least 60% alcohol if soap and water are not available.
- Avoid touching your eyes, nose, and mouth with unwashed hands.
- Cover coughs and sneezes.
- Routinely clean and disinfect frequently touched surfaces.
- Monitor your health daily. Be alert for symptoms of COVID-19 and take your temperature.

How long does it take for symptoms to develop?
The estimated *incubation period* (the time between being exposed and symptom onset) averages 4-5 days (median) and 5-6 days (mean) after exposure with a range of 2-14 days.

Is there a vaccine?
The U.S. Food and Drug Administration (FDA) has authorized the emergency use of several unapproved vaccines to prevent COVID-19 under an emergency access mechanism called Emergency Use Authorization (EUA). The FDA provides regularly updated information on COVID-19 Vaccines. The CDC provides COVID-19 vaccine information and guidance (see About COVID-19 Vaccines, Getting Your Vaccine, Types of Vaccines Available, Possible Side Effects, Safety and Monitoring, Effectiveness and When You've Been Fully Vaccinated.

Is there a treatment?
The Food and Drug Administration (FDA) has approved one drug, remdesivir (Veklury), to treat certain patients who are hospitalized with COVID-19. The FDA has also issued emergency use authorization (EUA) to allow healthcare providers to use certain products that are not yet approved, or that are approved for other uses, to treat patients with COVID-19 if certain legal requirements are met. Any treatments that are used for COVID-19 should be taken under the care of a healthcare provider. People have been seriously harmed and even died after taking unapproved products to self-treat. The National Institutes of Health (NIH) has developed and regularly updates COVID-19 Treatment Guidelines to help guide healthcare providers caring for patients with COVID-19.

What are variants?
Viruses constantly change through mutation. New variants of a virus are expected to occur. Multiple variants of the virus that causes COVID-19 have been identified in the United States and globally during the pandemic. Scientists are working to learn more about how easily they spread, whether they could cause more severe illness, and whether currently authorized vaccines will protect people against them.

COVID-19 Pandemic Response Plan Elements

1. Administration/Coordination

The Administration/Coordination element provides an overview of the plan in two phases: Preparation Steps for COVID-19 and Response Steps for Managing COVID-19. PREPARATION STEPS for COVID- 19 summarizes activities that all correctional facilities should be engaged in while preparing for the possibility of COVID-19 in the facility. The steps can be used as an outline for daily meetings about COVID-19 to quickly review the status of plan implementation. RESPONSE STEPS for MANAGING COVID-19 summarizes activities that should be implemented after case(s) of suspected or confirmed COVID-19 have been identified in the facility in either a staff or inmate.

PHASE I. PREPARATION STEPS for COVID-19

a) Coordination of Facility Response

- Train staff on the facility's COVID-19 Pandemic Response Plan. All personnel should have a basic understanding of COVID-19, symptoms of COVID-19, how COVID-19 spreads, and what measures are being implemented and can be taken by individuals to prevent or minimize the transmission of SARS-CoV-2.
- All individuals who have the potential for direct or indirect exposure to someone with COVID-19 or infectious materials (including body substances; contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air) should follow and monitor infection control practices outlined in the CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic and Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings – Recommendations of the HICPAC, with adaptation to reflect facility operations and custody needs.
- It is critically important that correctional and health care leadership meet or consult regularly to review the current status of COVID-19, review updated guidance from the Centers for Disease Control and Prevention (CDC) and the Hawaii Department of Health, and flexibly respond to changes in current conditions.
- Regular meetings (through video- or tele-conference when social distancing is not possible), should be held, roles and responsibilities for various aspects of the local response determined, and plans developed and rapidly implemented.
- Consideration should be given to activating the Emergency Response Plan within the facility to coordinate response to a crisis. Review existing influenza, all-hazards, and disaster plans, and revise for COVID-19.
- Responsibility should be assigned for tracking National and Local COVID-19 updates.

b) Coordination with Local Law Enforcement and Court Officials to Minimize Crowding

- Identify and implement legally acceptable alternatives to in-person court appearances (e.g., virtual court, as a social distancing measure to reduce the risk of SARS-CoV-2 transmission).
- Continue to explore strategies to reduce new intakes to the correctional facility with local law enforcement and court officials.
- Utilize existing policies for alternatives to incarceration and consider other decompression strategies where allowable.

c) Review Personnel Policies and Practices

- Review the most recent version of the Department of Human Resources Development instructions for "2019 Novel Coronavirus (COVID-19): Questions and Answers for Supervisors and Managers," currently Version #6, the CDC COVID-19 Critical Infrastructure Sector Response Planning, the CDC Interim Guidance for Businesses and Employers Responding to Coronavirus Disease 2019 (COVID-19), the Equal Employment Opportunity Commission's "Pandemic Preparedness in the Workplace and the Americans with Disabilities Act," and the Occupational Safety and Health Administration website.
- Review contingency plans for reduced staffing (e.g., Strategies to Mitigate Healthcare Personnel Staffing Shortages). Make plans in advance for how to change staff duty assignments to prevent unnecessary movement between housing units and other areas of the facility, to the extent possible (e.g., ensure the same staff are assigned to the same housing unit across shifts to prevent cross-contamination from units where infected individuals have been identified to units with no infections).
- Consider offering alternative duties to staff at increased risk of severe illness with COVID-19.
- Remind staff to stay at home if they are sick. To the extent possible, ensure sick leave policies are flexible, non-punitive, and actively encourage staff not to report to work when sick.
- Implement employee screening (see Element #5).
- Send staff home if they experience COVID-19 symptoms (e.g., fever, cough, or shortness of breath), while at work, and advise to follow CDC recommended steps for persons with COVID-19 symptoms.
- Except for rare situations, a test-based strategy is no longer recommended by CDC and HDOH to determine when to allow staff with SARS-CoV-2 infection to return to work. CDC and HDOH recommend the following symptom-based strategy for determining return to work.
    - Staff, who experienced *mild to moderate illness* and *are not severely immunocompromised*, may return to work after:
        - At least 10 days have passed since symptoms first appeared; **AND**
        - At least 24 hours have passed since last fever without the use of fever-reducing medications; **AND**
        - Symptoms have improved* (e.g., cough, shortness of breath)

        * Loss of taste and sense of smell may persist for weeks or months after recovery and need not delay the end of medical isolation.
    - Staff, who were *asymptomatic* throughout the infection and *are not severely immunocompromised*, may return to work after:
        - At least 10 days have passed since the date of collection of the first positive viral diagnostic test

- Staff, who experienced *severe to critical illness* or who *are severely immunocompromised*, may return to work after (consultation with an infectious diseases specialist is recommended):
  - At least 10 days and up to 20 days have passed since symptoms first appeared; **AND**
  - At least 24 hours have passed since last fever without the use of fever-reducing medications; **AND**
  - Symptoms have improved (e.g., cough, shortness of breath)
- Staff, who were *asymptomatic* throughout the infection and *are severely immunocompromised*, may return to work after (consultation with an infectious diseases specialist is recommended):
  - At least 10 days and up to 20 days have passed since the date of collection of the first positive viral diagnostic test

- Identify staff with COVID-19 Exposures (see definition of close contact in Element #12).
  - If a staff member has a confirmed COVID-19 infection:
    - [When testing on own] The staff member should adhere to the CDC guidance What to Do If You Are Sick.
    - [When testing at the facility] Immediately notify the individual of the positive result and advise the employee to adhere to the CDC guidance What to Do If You Are Sick.
    - Inform other staff about possible exposure to COVID-19 in the workplace (maintaining confidentiality in accordance with State and Federal laws, and as required by the Americans with Disabilities Act).
  - Employees, who are COVID-19 close contacts, should get tested 3-5 days after exposure to someone with suspected or confirmed COVID-19, consult their healthcare provider, self-monitor for symptoms and, if feasible, self-quarantine for 14 days (see 3 Key Steps to Take While Waiting for Your COVID-19 Test Result and Contact Tracing). According to the CDC, "The best way to protect incarcerated/detained persons, staff, and visitors is to quarantine for 14 days." As an alternative to the 14-day quarantine period for identified close contacts who do not reside in a correctional facility, HDOH adopted the CDC option to shorten the quarantine period to 10 days, ONLY if the following criteria are met:
    - No clinical evidence of COVID-19 has been elicited by daily symptom monitoring during the quarantine period, up to the time quarantine is discontinued;
    - Self-monitoring for symptoms of COVID-19 illness for a full 14 days after the last date of exposure;
    - Close contacts who develop symptoms within 14 days of the last exposure should be tested for COVID-19 and self-isolate while awaiting results; **AND**
    - Close contacts are informed to strictly adhere to all recommended mitigation strategies, including:
      - ❖ Correct and consistent mask use
      - ❖ Physical distancing
      - ❖ Hand and cough hygiene
      - ❖ Avoiding crowds
      - ❖ Environmental cleaning and disinfection
      - ❖ Ensuring adequate indoor ventilation

- The fully vaccinated employee, who is identified as a COVID-19 close contact, does not require quarantine and may continue to report to work if no symptoms have been experienced since exposure and the employee remains asymptomatic. HDOH recommends that employers who exempt vaccinated employees from quarantine only accept written, dated records as evidence of vaccination (see Sample Letter). Employees who do not produce written documentation of vaccination(s) are subject to quarantine requirements. The fully vaccinated employee should get tested 3-5 days after exposure to someone with suspected or confirmed COVID-19, consult their healthcare provider (people who have a condition or are taking medication that weaken the immune system may not be protected), self-monitor for symptoms, and strictly adhere to the mitigation strategies for close contacts detailed above. Symptomatic employees should be sent home. Note: in general, people are considered fully vaccinated two weeks after the second dose in a 2-dose series or two weeks after a single dose vaccine.
- If the fully vaccinated employee has a medical condition or is taking medication that weakens the immune system, the employee may NOT be protected and should continue to take all precautions recommended for unvaccinated people until advised otherwise by a healthcare provider.
- Employees, who have recovered from confirmed COVID-19 illness within the previous 3 months and remain without COVID-19 symptoms, do NOT require quarantine if exposed to someone with COVID-19.
- As a last resort and only in limited circumstances when it is necessary to preserve the function of critical infrastructure workplaces (e.g., when cessation of operation of a facility may cause serious harm or danger to public health or safety), the facility Warden or Administrator, in collaboration with HDOH, may consider allowing an exposed and asymptomatic critical infrastructure worker (e.g., adult correctional officers, law enforcement officers, and healthcare workers), to continue to work following exposure to a person with suspected or confirmed COVID-19 provided the employee remain asymptomatic and has not tested positive.

  Additionally, the following risk mitigation precautions should be implemented to protect the critical infrastructure worker and others prior to and during the work shift:

  - Pre-Screen: The employee should self-screen at home prior to arriving onsite. The employee should not attempt to enter the workplace if any of the following are present: symptoms of COVID-19; temperature equal to or higher than 100.0 ^{o}F; or are waiting for the results of a viral test.
  - Screen at the Workplace: Before the employee enters the facility, employers should conduct an on-site symptom assessment, including temperature screening, prior to each work shift.
  - Regular Monitoring: Under supervision, the employee should self-monitor and report to the supervisor the development of a temperature or other symptoms. To the extent possible, complete the self-monitoring form for asymptomatic workers with low risk exposure or the active monitoring form for asymptomatic workers with high risk exposure (see also Flowchart for management of HCWs with exposure to a person with COVID-19).

- Wear a Mask: The employee should wear a mask (unless contraindicated) at all times while in the workplace for 14 days after the last exposure and/or in accordance with CDC and OSHA guidance and any state or local requirements.
- Social Distance: The employee should maintain 6 feet of physical distance from others and practice social distancing as work duties permit in the workplace.
- Disinfect and Clean Workspaces: Continue enhanced cleaning and disinfecting practices in all areas, especially frequently touched surfaces and objects, including offices, bathrooms, common areas, and shared equipment (refer to CDC Cleaning and Disinfecting Your Facility).

d) Communication (Element #2)

- Initiate and maintain ongoing communication with local public health authorities.
- Communicate with community hospitals about procedures for transferring severely ill inmates.
- Develop and implement ongoing communication plans for staff, inmates, and families.

e) Implement General Prevention Measures (Element #3)

- Promote good health habits among employees (Table 1).
- Review protocols or practices regarding alcohol-based hand sanitizer use by employees.
- Conduct frequent environmental cleaning of high touch surfaces (refer to CDC Cleaning and Disinfecting Your Facility). Increase the number of inmate workers assigned to this duty.
- Implement social distancing measures to prevent the spread of germs. Review the list of possible social distancing measures in Element #3 and develop plans for individual facilities to implement at different levels of transmission intensity.
- Encourage the use of masks (unless contraindicated). Utilize no-contact barriers for inmate encounters as a supplement to the use of masks, where feasible.
- Minimize inmate movements within and between facilities. Consider limiting the transfer of inmates to and from other jurisdictions and facilities, unless necessary for medical evaluation, medical isolation/quarantine, clinical care, extenuating security concerns, release, or to prevent overcrowding. Depending on the degree of local community transmission and potential for patient harm, adhere to the CDC Framework for Healthcare Systems Providing Non-COVID-19 Clinical Care During the COVID-19 Pandemic.
- Implement infection prevention control guidance for screening of employees, visitors/vendors/volunteers, and new intakes (Element #3).

f) Visitors/Vendors/Volunteers (Element #4)

- Communicate with potential visitors.
- Conduct screening of visitors, vendors, and volunteers.

g) Continue to Conduct Employee Screening (Element #5)

h) Continue to Conduct New Intake Screening (Element #6)

i) Appropriately Manage and Test Symptomatic Inmates (Element #7)

- Provide education to all staff about source control and the importance of immediately providing a mask to inmates with symptoms of COVID-19.
- Suspend co-pays for inmates seeking medical evaluation for COVID-19 symptoms and implement COVID-19 testing of symptomatic inmates.

j) Attempt to Acquire Needed Personal Protective Equipment (PPE) and Other Supplies (Element #8)

- Ensure a sufficient stock of hygiene supplies, cleaning supplies, personal protective equipment (PPE), and medical supplies are available and plan for re-stocking.
- Review Table 3. COVID-19 Personal Protective Equipment Recommendations and post as needed in the facility.
- Implement staff and inmate training on donning, doffing, and disposing PPE relevant to the level of contact with infectious materials anticipated from inmates with suspected and confirmed COVID-19.

k) Provide Training to Transport Officers on Safe Transport Utilizing PPE (Element #9)

- Identify staff who will provide transport.
- Identify staff who will provide training and document the training.

l) Identify Cells and Housing to be used for Medical Isolation (Element #10**) and Quarantine (**Element #12**)**

Ensure that **separate** physical locations (dedicated housing areas and bathrooms) have been identified to 1) medically isolate inmates with confirmed COVID-19 (individually or cohorted), 2) medically isolate inmates with suspected COVID-19 (individually – do not cohort), and 3) quarantine close contacts of those with confirmed or suspected COVID-19 (ideally individually; cohorted if necessary). The plan should include contingencies for multiple locations if numerous infected inmates and/or close contacts are identified and require medical isolation or quarantine simultaneously. Note: Cohorting refers to the practice of medically isolating multiple inmates with laboratory-confirmed COVID-19 together or quarantining close contacts of an infected person together as a group due to a limited number of individual cells.

- Print out color CDC Contact Precautions and CDC Droplet Precautions signs (Attachments #3 and #4). Print out color Isolation and Quarantine signs (Attachments #5 and #6).
- Review how staff will be assigned to work in isolation/quarantine areas.
- Appropriately train staff and inmates who work in laundry and food service.
- Train staff and inmate workers on how to clean areas where COVID-19 inmates spent time.

m) Health Care Staff Should Review Medical and Nursing Procedures for Caring for the Sick (Element #11)

- Maintain communication with the Medical Director and the Hawaii Department of Health to determine how COVID-19 testing will be performed and recommended criteria for testing.
- Encourage the use of existing no-contact barriers for patient encounters.
- Explore options for expanding telehealth capabilities.

PHASE II. RESPONSE STEPS for MANAGING COVID-19

a) Implement alternative work arrangements for staff, as deemed feasible. Determine where inmates should be allowed to work, depending on exposure history.

b) Suspend all transfers of inmates to and from other jurisdiction and facilities unless necessary for medical evaluation, medical isolation/quarantine, health care, extenuating security concerns, release, or to prevent overcrowding.

c) When possible, arrange for lawful alternatives to in-person court appearances.

d) Implement Routine Intake Quarantine of new admissions to the facility, including inmates returning after more than 24 hours away from the facility, for 14 days before housed with the existing population, if possible.

e) Incorporate screening for COVID-19 symptoms and a temperature check into release planning. Provide releasing inmates with COVID-19 Re-entry Care Packs, which include one mask, the COVID-19 Re-entry Information Handout (see Attachment 7), and county-specific community resources handouts. Provide releasing inmates, who are under medical isolation or quarantine, with education about recommended follow-up.

f) Communicate with community hospitals about the potential need to transfer severely ill inmates.

g) Hygiene

- Continue to ensure that hand hygiene supplies are well-stocked in all areas of the facility.
- Continue to emphasize proper hand hygiene practices and cough etiquette.
- Encourage staff to change clothes before leaving the worksite and designate a location for changing clothes.

h) Environmental Cleaning

- Continue to emphasize the importance of cleaning and disinfection (refer to CDC Cleaning and Disinfecting Your Facility).
- Ensure compliance with the specific cleaning and disinfection procedures for areas where a COVID-19 case spent time (Element #10).

i) Implement medical isolation of confirmed or suspected COVID-19 cases (Element #10).

- Assess adequacy of PPE for staff working in medical isolation areas (see Element #8).
- Implement telehealth modalities, if possible.
- When there are space constraints related to medical isolation, consult with the health care provider and the Hawaii Department of Health on decisions about placement.

j) Implement quarantine of close contacts of COVID-19 cases (Element #12).

- Assess adequacy of PPE for staff working in quarantine areas (see Element #8).
- Require all inmates wear masks while in quarantine, except when contraindicated or not feasible.
- When there are space constraints related to quarantine, consult with the health care provider and the Hawaii Department of Health on decisions about placement.

k) In the event of a COVID-19 outbreak, consult with the Medical Director and the Hawaii Department of Health on the recommended viral testing strategy for inmates and staff. Prior to conducting widespread testing, determine how test results will be used to make housing and movement decisions (i.e., where to house inmates with positive test results, negative test results with known exposure, and negative test results with no known exposure).

l) Implement a system for tracking information about inmates and staff with suspected/confirmed COVID-19 (Element #14).

2. Communication

- Communicate regularly with staff, the incarcerated population, and their families. Specific methods for communicating COVID-19 information should be established. Test communication plans to disseminate critical information to inmates, staff, contractors, vendors, visitors, and volunteers.
- Communication should be understandable for non-English speaking and low literacy persons. Provide accommodations for those with cognitive or intellectual disabilities and those who are deaf, blind, or have low vision. Staff should be assigned to be responsible for crafting and disseminating regular updates.
- Post signage throughout the facility to communicate the Symptoms of COVID-19 and measures of prevention such as Hand Hygiene, Social Distancing, and Mask Use. CDC Stop the Spread of Germs posters were distributed to all correctional facilities. Post signage to remind staff to Stay at Home When Sick. Communication Resources are available on the CDC website.

- As much as possible, provide COVID-19 information in person and allow opportunities for inmates and employees to ask questions (e.g., town hall format if social distancing is feasible, informal peer-to-peer education).
- Examples of key communication messages for employees (refer to COVID-19 Communication Plan for Select Non-healthcare Critical Infrastructure Employers for methods of communication, additional key messages, and communication resources):
    - Provide updates on the status of COVID-19 within the facility.
    - The importance of staying home if signs or symptoms of COVID-19 are present.
    - The importance of staying home if there is known exposure to COVID-19.
    - Reminders about good health habits to protect themselves, emphasizing cough/sneeze etiquette and hand hygiene.
    - Elements of the facility COVID-19 Pandemic Response Plan to keep employees safe, including the universal use of masks (unless contraindicated or PPE is indicated) and the importance of social distancing.
- Examples of key communication messages to inmates:
    - The importance of immediately reporting COVID-19 symptoms (and reporting if another inmate is experiencing COVID-19 symptoms in order to protect themselves). Establish procedures on how to report symptom observations.
    - Reminders about good health habits to protect themselves, emphasizing cough/sneeze etiquette, hand hygiene, and reminders to use masks as much as possible.
    - Educate that sharing drugs and drug preparation equipment can spread SARS-CoV-2 due to potential contamination of shared items and close contact between inmates.
    - Plans to support communication with family members (when personal visits are suspended or reduced).
    - Plans to keep inmates safe, including the presence of COVID-19 within the facility and the importance of social distancing.
    - The purpose of medical isolation and quarantine. Address concerns about medical isolation and explain the difference between medical isolation and disciplinary segregation.
- Contact should be made and maintained with the Medical Director and the Hawaii Department of Health to obtain guidance, especially about managing and testing inmates with COVID-19.
- Communication should also be established with local community hospitals to discuss referral mechanisms for seriously ill inmates.

3. General Prevention Measures

Throughout the duration of the COVID-19 pandemic, the following general prevention measures should be implemented to interrupt viral infection transmission (see *Table 1* below).

Table 1. General Prevention Measures

a. **Promote good health habits** among employees and inmates:
   1) Avoid close contact with persons who are sick.
   2) Avoid touching your eyes, nose, or mouth without cleaning your hands first.
   3) Wash your hands often with soap and water for at least 20 seconds.
   4) Cover your sneeze or cough with a tissue (or into a sleeve), then throw the tissue in the trash.
   5) Avoid non-essential physical contact. No hugs, handshakes, fist bumps, or high-fives.
   6) Avoid sharing eating utensils, dishes, and cups.

b. **Conduct frequent environmental cleaning of "high touch" surfaces.**

c. **Institute social distancing measures to prevent the spread of germs** (i.e., examine and implement methods to ensure at least 6 feet of distance between individuals, when possible).

d. E**ncourage the use of masks and other no-contact barriers**.

e. **Employees must stay at home if they are sick.**

f. **Establish facility protocols to access the COVID-19 vaccine.**

g. **Influenza (flu) vaccine is recommended for persons not previously vaccinated.**

h. **Follow infection prevention and control guidance when conducting screening.**

i. **Utilize control strategies for aerosol generating procedures.**

a. Good Health Habits

- Good health habits should be promoted in various ways (e.g., educational videos/posters, assessing adherence to cough etiquette and hand hygiene).
- All employees and inmates should view the COVID-19 educational video, which includes measures of prevention and detailed handwashing procedures (see also Handwashing).
- The CDC Stop the Spread of Germs poster should be posted throughout the facility. The CDC website has additional helpful educational posters: CDC Posters
- Each facility should ensure that adequate supplies and facilities are available for handwashing for both inmates and employees.
- With approval of the Warden, health care workers should have access to alcohol-based hand rub.
- Provisions should be made for employees, visitors, vendors, volunteers, and new intakes to wash their hands when they enter the facility.
- To the extent possible, provide and continually restock hygiene supplies throughout the facility, including in bathrooms, food preparation and dining areas, intake areas, visitor entries and exits, visitation rooms and waiting rooms, common areas, medical and staff-restricted areas (e.g., break rooms).

- In order to help minimize the risk of transmitting SARS-CoV-2 between the facility and the community, encourage staff to change clothes before leaving the worksite and designate a location for changing clothes.

b. Environmental Cleaning

- The virus that causes COVID-19 can land on surfaces. It is possible for people to become infected if they touch those surfaces and then touch their nose, mouth, or eyes. In most situations, the risk of infection from touching a surface is low. The most reliable way to prevent infection from surfaces is to regularly wash hands or use hand sanitizer. Cleaning and disinfecting (using U.S. Environmental Protection Agency (EPA)'s List N) surfaces can also reduce the risk of infection.
- Implement routine and intensified cleaning and disinfecting procedures in accordance with the CDC guidance on Cleaning and Disinfecting Your Facility Every Day and When Someone is Sick and OSHA standards.
- Cleaning with products containing soap or detergent reduces germs on surfaces by removing contaminants and may also weaken or damage some of the virus particles, which decreases risk of infection from surfaces. When no people with confirmed or suspected COVID-19 are known to have been in a space, cleaning once a day is usually enough to sufficiently remove virus that may be on surfaces. Clean more frequently or disinfect (in addition to cleaning) in shared spaces if certain conditions apply that can increase the risk of infection from touching surfaces:
  - High touch surfaces,
  - Food service, Intake, Medical Unit,
  - High transmission of COVID-19 in the community,
  - Low number of people wearing masks,
  - Infrequent hand hygiene, or
  - The space is occupied by people at increased risk for severe illness from COVID-19
- If there has been a sick person or someone who tested positive for COVID-19 in the facility within the last 24 hours, then clean and disinfect the space. If more than 24 hours have passed since someone who was sick or diagnosed with COVID-19 was in the facility, then clean the space and determine if disinfection is required (review Cleaning and Disinfecting Your Facility). If more than 3 days have passed, then regular cleaning practices are indicated.
- Routinely clean and disinfect surfaces and objects that are frequently touched, especially in common areas. These may include doorknobs, light switches, sink handles, countertops, toilets, toilet handles, recreation equipment, kiosks, telephones, computer equipment, handrails, elevator buttons, cell bars, etc.
- One strategy is to increase the number of workline inmates who are assigned to conduct continual cleaning of common areas throughout the day.

- Staff should clean shared equipment (e.g., radios, service weapons, keys, handcuffs, computer equipment, telephones), after shared use and when the use of equipment has concluded.
- Hard (non-porous) Surfaces:
  - If surfaces are dirty, clean using a detergent or soap and water prior to disinfection.
  - Consult the EPA List N: Disinfectants for Coronavirus (COVID-19). Follow the manufacturer's instruction for all cleaning and disinfection products (e.g., concentration, application method and contact time, etc.).
  - If EPA-approved disinfectants are not available, diluted, unexpired household bleach can be used if appropriate for the surface. Never mix household bleach with ammonia or any other cleanser.
  - Refer to CDC guidance on How to Make 0.1% Chlorine Solution to Disinfect Surfaces in Healthcare Settings (see also illustration).
  - Alcohol solutions with at least 70% alcohol may also be used.
  - One supplemental strategy for disinfection of hard, non-porous surfaces in large and difficult to reach areas is the timely and routine use of fogging devices, which dispense products with emerging viral pathogens and human coronavirus claims for use against SARS-CoV-2 (consult the EPA Product List of Disinfectants for Use Against SARS-CoV-2 and review Safety Precautions When Using Electrostatic Sprayers, Foggers, Misters, or Vaporizers for Surface Disinfection During the COVID-19 Pandemic).
- Soft (porous) Surfaces (e.g., carpeted floor, rugs, drapes):
  - Remove visible contamination and clean with appropriate cleaner for soft surfaces.
  - If washable, launder in hottest water setting for the item and dry completely.
  - Or, use products with EPA-approved viral pathogens claims.
- Electronics:
  - Remove visible contamination, if present.
  - Follow the manufacturer's instructions for all cleaning and disinfection of products.
  - Consider use of wipeable covers for electronics.
  - If no manufacturer guidance is available, consider the use of alcohol-based wipes or spray containing at least 70% alcohol to disinfect touch screens and other surfaces. Dry surfaces thoroughly to avoid pooling of liquids.
- CDC provides guidance on heating, ventilating, and air-conditioning (HVAC) systems to help reduce the airborne concentration of the virus that causes COVID-19 (see Guidelines for Environmental Infection Control in Health-Care Facilities and Ventilation in Buildings).

c. Social Distancing Measures

Social distancing, or physical distancing, means keeping space between all individuals (ideally at least 6 feet) regardless of symptoms and decreasing the frequency of contact between individuals. Various administrative measures should be implemented to lessen the chance of spreading the virus by reducing close contact between people. Due to differences among correctional facilities, facility administration should discuss and implement social distancing measures specific for the individual facility, as allowable by physical plant limitations, security restrictions, and operational resources. Examples of possible social distancing strategies for use at individual facilities include:

- Common Areas
  - Provide educational reminders to stay at least 6 feet from others.
  - Provide visual reminders (e.g., tape, paint), on floor surfaces every six feet in walking areas.
  - Enforce increased space between inmates in holding cells, lines, and waiting areas.
  - Remove every other chair in a waiting area.
- Recreation
  - Utilize recreation areas where inmates can spread out, if available.
  - Stagger time in recreation spaces.
  - Restrict recreation space usage to a single housing unit, where feasible.
  - Suspend close-contact sports (e.g., basketball). Encourage individual exercises (e.g., walking).
  - Clean and disinfect equipment after individual use and between group use.
- Meals
  - Stagger meals in the dining hall, if possible (one housing unit at a time; clean and disinfect between groups).
  - Rearrange seating in dining hall to increase space between inmates (e.g., remove every other chair or use only one side of table).
  - Increase meals to cell opportunities.
  - Implement a rotational system among inmates for dining at the cafeteria.
- Group Activities
  - Limit the size of group activities.
  - Increase space between individuals during group activities.
  - Reduce the number of group participants to ensure physical separation of at least 6 feet between participants.
  - If available, consider the use of alternative settings to usual group activities (e.g., outdoor recreation areas, module dayroom areas, or other areas where inmates can spread out).
  - Suspend group programs where participants are likely to be in closer contact than they are in their housing environment. [Note: when discontinuing group activities, it is important to provide alternative forms of activity to support the mental health of inmates during the pandemic.]

- Education and Program Services
  - Convert the educational or program curriculum to self-study, if possible.
  - Consider the use of video modalities for education and other programs, if available.
  - Use no-contact barriers when meeting with inmates, if possible.
  - Limit the size of program participants to ensure physical separation of at least 6 feet between participants in the classroom.
  - Explore alternatives to in-person education.
- Housing
  - Arrange bunks so that inmates sleep head to foot.
  - If space allows, reassign bunks to provide more space between inmates (ideally 6 feet or more in all directions).
  - Minimize the number of inmates housed in the same room as much as possible.
  - Minimize mixing inmates from different housing units (e.g., workline, program attendance).
  - Conduct thorough cleaning and disinfection of living space when inmates leave.
- Health Care
  - Use no-contact barriers when meeting with inmates, if possible.
  - Use telehealth for virtual clinic visits with Providers, forensic examiners, community-based case managers, and other professional service providers, if available.
  - If available, designate a room near the intake area to evaluate new intakes with COVID-19 symptoms or exposure risk before the inmate moves to other parts of the facility.
  - If possible, designate a room near each housing unit to evaluate inmates with COVID-19 symptoms, rather than having inmates with COVID-19 symptoms walk through the facility to be evaluated in the medical unit. If designating a room near each housing unit is not feasible, consider staggering inmate sick call visits.
  - Stagger pill-lines or administer medication at modules.
  - Consider increased use of keep on person (KOP) medication orders.
- Minimize Inmate Movement
  - Avoid transferring inmates between living areas, when possible.
  - Modify work detail assignments so that each detail includes only individuals from a single housing unit. If a workline provides goods or services (e.g., food service or laundry), for other housing units under medical isolation or quarantine, ensure that deliveries are made with extreme caution (e.g., workline delivers prepared food to a set location, leaves, and then staff or workline from the housing unit pick up the delivery. Clean and disinfect all coolers, carts, and other objects involved in the delivery).
  - Depending on the degree of local community transmission, suspend work furlough and other programs that involve inmate movement in and out of the facility. When work furlough or other programs resume, implement facility protocols to cohort work furlough and other transiently housed inmates with routine quarantine measures while at the facility, if possible.

- Depending on the degree of local community transmission and potential for patient harm, adhere to the CDC Framework for Healthcare Systems Providing Non-COVID-19 Clinical Care During the COVID-19 Pandemic. Prioritize services that, if deferred, are most likely to result in patient harm. Prioritize at-risk populations who would benefit most from services (e.g., inmates with serious underlying health conditions, inmates most at-risk for complications from delayed care, or inmates without access to telehealth). When returning from outside facility appointments, implement routine quarantine measures for inmates who return to the facility, if possible.

- Re-entry
  - Ensure the facility re-entry programs include information on accessing housing, social services, mental health services, and medical care within the context of social distancing restrictions and limited community business operations related to COVID-19.
  - Where possible, encourage releasing inmates to seek housing options among their family or friends in the community to prevent crowding in other congregate settings such as homeless shelters.
  - When linking inmates to shared housing, link preferentially to accommodations with the greatest capacity for social distancing.
- Provide video or telephonic visitation, if available. When visitation resumes, use no-contact barriers and no-contact visit stations, if available.

d. Encourage the use of Masks and Other No-Contact Barriers

- Transmission of SARS-CoV-2 occurs from individuals who are symptomatic, asymptomatic (i.e., absence of symptoms), and pre-symptomatic (i.e., prior to the development of symptoms). This means COVID-19 could spread between people interacting in close proximity, even if those people are not exhibiting symptoms.
- Encourage inmates to use masks provided at no cost by the facility and launder the masks routinely. Require employees and others present at correctional facilities to use masks to the extent possible. Anyone who has trouble breathing, is unconscious, incapacitated or otherwise unable to remove the mask without assistance should not use masks (refer to additional CDC Considerations for Wearing Masks for conditions and situations that may require adaptation).
- Educate inmates, employees, and others at correctional facilities on How to Select, Wear, and Clean Your Mask (see also Guidance for Wearing Masks, How to Wear Masks, Improve the Fit and Filtration of Your Mask to Reduce the Spread of COVID-19, Improve How Your Mask Protects You, Types of Masks, Facemask Do's and Don'ts, How to take off a mask, and How to Store and Wash Masks). CDC recommends masks that have two or more layers of washable, breathable, tightly woven fabric (e.g., cotton and cotton blends); completely cover the nose and mouth and secure it under the chin; fit snugly against the sides of the face and do not have gaps; and be handled only by the ear loops, cords, or head straps (not by the surface of the mask). CDC does NOT recommend masks that are made of single layer, loosely woven, hard to breath fabric (e.g., vinyl, plastic, leather). CDC does NOT recommend masks that have exhalation valves or vents for source control.

- The use of masks helps protect the wearer from getting COVID-19 and helps the wearer, who has the virus and does not know it, from transmitting it to others (see CDC Use of Masks to Help Slow the Spread of COVID-19). If everyone wears a mask in congregate settings, the risk of exposure to SARS-CoV-2 can be reduced. Clearly explain the purpose of masks: "My mask protects you, your mask protects me." Note: masks are a type of source control intended to help slow the spread of COVID-19 and are not Personal Protective Equipment (PPE). Masks are not surgical masks or respirators.
- The use of a gaiter with two layers or folding the gaiter to make two layers is an acceptable substitute for masks. Due to insufficient evidence to support the use of face shields for source control, CDC does not recommend the use of face shields as a substitute for masks.
- Utilize no-contact barriers for inmate encounters as a supplement to the use of masks, where feasible. A mask is NOT a substitute for social distancing.

e. Sick/Exposed Employees Remain Home

- COVID-19 could gain entrance to a facility via infected employees. Staff should be educated to stay home if they have COVID-19 symptoms.
- If employees develop fever, cough, shortness of breath, or other COVID-19 symptoms at work, they should be advised to immediately put on a mask, promptly inform their supervisor, leave the facility, and follow CDC recommended steps for persons who are ill with COVID-19 symptoms.
- Employees should be advised to consult their health care provider by telephone.
- If employees have been exposed, to a known COVID-19 case, adhere to the most recent version of the Department of Human Resources Development instructions for "2019 Novel Coronavirus (COVID-19): Questions and Answers for Supervisors and Managers," currently Version #6, COVID-19 Critical Infrastructure Sector Response Planning, Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to COVID-19, Guidance for Businesses and Employers Responding to Coronavirus Disease 2019 (COVID-19), Strategies to Mitigate Healthcare Personnel Staffing Shortages, the Equal Employment Opportunity Commission's "Pandemic Preparedness in the Workplace and the Americans with Disabilities Act," and Occupational Safety and Health Administration standards.
- In addition to physical and medical considerations, the CDC provides information for employees on How to Cope with Job Stress and Build Resilience During the COVID-19 Pandemic (see also Coping with Stress, Grief and Loss, Fatigue, and specific information for Healthcare Personnel and First Responders). Employees seeking mental health assistance are encouraged to contact their Primary Care Provider or the Employee Assistance Program (WorkLifeHawaii.org): Oahu at (808) 543-8445 or Neighbor Islands and After Hours at (800) 994-3571. Additional sources of help include:

  National Suicide Prevention Lifeline at 800-273-TALK (800-273-8255)

  National Domestic Violence Hotline call 800-799-7233 or TTY 800-787-3224

  Disaster Distress Helpline call 800-985-5990 or text TalkWithUs to 66746

  Hawaii CARES Crisis Helpline call 808-832-3100 or 800-753-6879

f. COVID-19 Vaccination

The U.S. Food and Drug Administration (FDA) has authorized the emergency use of several unapproved vaccines to prevent COVID-19 under Emergency Use Authorization (EUA). The FDA provides regularly updated information on COVID-19 Vaccines. The CDC recommends getting a COVID-19 vaccine (see also COVID-19 Vaccine FAQs in Correctional and Detention Centers). The CDC reports "COVID-19 vaccination will help protect you from getting COVID-19" and "COVID-19 vaccines are safe and effective."

- Offer the COVID-19 vaccine to all inmates (existing population and new intakes). Provide education about COVID-19 vaccines and opportunities to ask questions and receive responses.
- The CDC provides the following COVID-19 vaccine information:
  - About COVID-19 Vaccines - Benefits of Getting a COVID-19 Vaccine, Key Things to Know, Frequently Asked Questions, and Vaccine Data.
  - Getting Your Vaccine - How to Find a COVID-19 Vaccine, Preparing for COVID-19 Vaccination, COVID-19 Vaccine Information for Specific Groups, and What to Expect When Getting the Vaccine.
  - Types of Vaccines Available - How COVID-19 Vaccines Work with specific information on mRNA COVID-19 Vaccines and Viral Vector COVID-19 Vaccines; and COVID-19 vaccine overview and safety for Pfizer-BioNTech, Moderna, and Johnson & Johnson's Janssen.
  - Possible Side Effects – common side effects include pain, redness and swelling on the arm the vaccine was administered; tiredness, headache, muscle pain, chills, fever, nausea (see also What to Expect after Getting a COVID-19 Vaccine).
  - Safety and Monitoring, - What to Do if You Have an Allergic Reaction After Getting A COVID-19 Vaccine, Safety of COVID-19 Vaccines, Reported Adverse Events, and Vaccine Reporting Systems.
  - Effectiveness.
  - When You've Been Fully Vaccinated - Interim Public Health Recommendations for Fully Vaccinated People [Note: the interim guidance may not apply where required by federal, state, or county laws, rules, and regulations, including workplace guidance; the interim recommendations for fully vaccinated people concerning medical isolation, quarantine, and testing may not apply to workers and residents at correctional centers and facilities].

The CDC provides COVID-19 vaccine clinical resources for healthcare workers:

- Clinical Care Considerations for COVID-19 Vaccination
  - Interim Clinical Considerations for Use of COVID-19 Vaccines Currently Authorized in the United States
  - Interim Considerations: Preparing for the Potential Management of Anaphylaxis after COVID-19 Vaccination

  - Clinical Consideration: Myocarditis and Pericarditis after Receipt of mRNA COVID-19 Vaccines Among Adolescents and Young Adults
  - Lab Tests to Collect Shortly After Severe Allergic Reaction/Anaphylaxis Following COVID-19 Vaccination
  - The Advisory Committee on Immunization Practices (ACIP) has issued interim recommendations for the use of Pfizer-BioNTech, Moderna, and Janssen/Johnson & Johnson COVID-19 vaccines for the prevention of coronavirus disease 2019 (COVID-19) in the United States.

- U.S. COVID-19 Vaccine Product Information, including changes and updates; general vaccine information (i.e., dosage, age indication, schedule, and route of administration); administration overview with contraindications/precautions and directions to thaw, prepare and administer; Prevaccination Screening Form; standing orders (i.e., Pfizer-BioNTech, Moderna, Janssen); and Preparation and Administration Summary (i.e., Pfizer-BioNTech, Moderna, Janssen).
  - Pfizer-BioNTech
  - Moderna
  - Janssen
- CDC COVID-19 Vaccination Program Provider Requirements and Support , which includes requirements for vaccine administration reporting and documentation, directions for reporting adverse events to the Vaccine Adverse Event Reporting System (VAERS), instructions on How to Enroll as a COVID-19 Vaccination Provider, and Inventory Management Best Practices.
- Training and Education modules with core competencies required by professional qualification, as well as specific information on Safe and Proper Sharps Disposal During the COVID-19 Mass Vaccination Campaign.
- Vaccine Recipient Education, including various educational handouts, instructions on How to talk to patients about COVID-19 vaccination, and Answering Patients' Questions About COVID-19 Vaccine and Vaccination (see also COCA webinar on how to address patient questions and concerns about vaccines).
- COVID-19 Vaccine Breakthrough Case Investigation and Reporting. Vaccine breakthrough infection is defined as the detection of SARS-CoV-2 RNA or antigen in a respiratory specimen collected from a person ≥14 days after they have completed all recommended doses of a U.S. Food and Drug Administration (FDA)-authorized COVID-19 vaccine. Vaccine breakthrough cases are expected. No vaccine is 100% effective at preventing illness in vaccinated people. If COVID-19 infection is suspected in a person who received a complete primary series and it has been at least 14 days since the last dose:

- Collect a respiratory specimen for SARS-CoV-2 diagnostic testing
- For patients with positive respiratory specimen results:
  - Forward positive specimen to the State Laboratories Division (SLD) for whole genome sequencing analysis
  - Report the case to HDOH
  - Submit a Vaccine Adverse Event Reporting System (VAERS) report at: https://vaers.hhs.gov/reportevent.html

- Vaccine Effectiveness Research.

g. Influenza Vaccination

- During influenza season, flu vaccination remains an important measure to prevent an illness that presents similarly to COVID-19. The CDC provides Interim Guidance for Routine and Influenza Immunization Services During the COVID-19 Pandemic.
- Encourage correctional employees to obtain flu vaccination.
- Offer the seasonal influenza vaccine to all inmates (existing population and new intakes). Implement the HCD inmate influenza vaccine campaign (see Attachment 9) to encourage improved compliance through positive behavioral reinforcement.

h. Infection Prevention and Control Guidance for Screening

Protocol when conducting temperature checks:

- Perform hand hygiene, (i.e., Wash hands with soap and water for at least 20 seconds. If soap and water are not available, use hand sanitizer with at least 60% alcohol).
- Put on a surgical mask, eye protection (goggles or disposable face shield that fully covers the front and sides of the face) and disposable gloves [in facilities with PPE shortage, CDC provides Strategies to Optimize the Supply of PPE and Equipment].
- Check the individual's temperature. Refer to Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic for information on proper thermometer usage and factors that could impact thermometer readings.
  - Non-contact or disposable thermometers are preferred over reusable oral thermometers.
  - If performing temperature checks on multiple individuals, put on new gloves for each individual screen and thoroughly clean the thermometer between each screen.
  - If disposable or non-contact thermometers are used and the screener did not have physical contact with an individual, gloves do not need to be changed before the next screen. If non-contact thermometers are used, they should be cleaned with an alcohol wipe (or isopropyl alcohol on a cotton swab) between each individual.
- Remove and discard PPE.
- Perform hand hygiene.

Protocol when conducting temperature checks if a physical barrier or partition is used to protect the screener rather than a PPE-based approach (During screening, the screener stands behind a physical barrier, such as a plexiglass partition, which protects the screener's face and mucous membranes from respiratory droplets that may be produced when the person being screened sneezes, coughs, or talks):

- Perform hand hygiene.
- Put on disposable gloves [in facilities with PPE shortage, CDC provides Strategies to Optimize the Supply of PPE and Equipment].
- Check the individual's temperature by reaching around the partition or through the window. The screener's face must remain behind the barrier at all times during the screening.
  - Non-contact or disposable thermometers are preferred over reusable oral thermometers.
  - If performing temperature checks on multiple individuals, put on new gloves for each individual screen and thoroughly clean the thermometer between each screen.
  - If disposable or non-contact thermometers are used and the screener did not have physical contact with an individual, gloves do not need to be changed before the next screen. If non-contact thermometers are used, they should be cleaned with an alcohol wipe (or isopropyl alcohol on a cotton swab) between each individual.
- Remove and discard gloves.
- Perform hand hygiene.

i. Control Strategies for Aerosol Generating Procedures

- Refer to Attachment 8 for recommended control strategies during aerosol generating procedures, including SARS-CoV-2 specimen collection, emergency dental procedures, CPAP/BiPAP, pulmonary function tests/peak flow tests, nebulizer treatment, and CPR.
- Adhere to the CDC Interim Infection Prevention and Control Guidance for Dental Settings During the COVID-19 Response and guidance from the Hawaii Board of Dentistry (see Dental COVID-19 FAQ).

4. Visitors / Vendors / Volunteers

- Provide visitors, vendors, and volunteers with information to prepare them for screening. Instruct visitors to postpone their visit if they have COVID-19 symptoms. Display signage outside visiting areas explaining the COVID-19 screening process. Ensure that materials are understandable for non-English speakers and those with low literacy.
- Implement COVID-19 screening of visitors, vendors, and volunteers in accordance with State and County requirements (Attachment 1A or Attachment 1B). Visitors, vendors, and volunteers who do not clear the screening process or who decline screening should be denied entrance to the facility.
- To the extent possible and unless contraindicated, visitors, vendors, and volunteers should be required to wear a mask or a higher medical grade mask while present at correctional facilities.

- Depending on the degree of local community transmission, consideration should be given to limiting access to the facility by visitors, volunteers, and non-essential vendors.
- Promote non-contact visits and encourage alternatives to in-person visitation. If the facility resumes in-person non-contact visits, consider staggered and scheduled visitation to enforce adequate social distancing (e.g., in visitation waiting lines, screening, and the visitation area). In-person non-contact visitation areas should be cleaned regularly after each use.
- If suspending in-person visitation in the interest of inmates' physical health and the health of the general public, facilities should explore alternative ways for inmates to communicate with their families, friends, and other visitors in a way that is not financially burdensome for them. Arrangements should be made to increase options for inmates to communicate with their families via telephone or video visitation, where possible. Consider reducing or temporarily eliminating the cost of phone calls. Consider increasing inmates' telephone privileges. Visitation is important to maintain mental health. If the facility utilizes virtual visitation, clean electronic surfaces regularly after each use.
- If suspending in-person visits, provide alternative means (e.g., telephone or video visitation), for inmates to engage with legal representatives, clergy, and other individuals whom they have a legal right to consult.

5. Employee Screening

- In locations where it is identified that there is sustained COVID-19 community transmission, employees should be screened upon arrival using the COVID-19 Employee Screening form, which asks questions about COVID-19 symptoms, COVID-19 positive results, travel, contact with a known or suspected COVID-19 individual, and temperature check, in accordance with State and County requirements (Attachment 2A or Attachment 2B).
- Facilities might choose to laminate employee screening forms (not the visitor/vendor/volunteer screening form), and have employees review the screening questions and verbally respond to them. Employees can then sign a log book that includes date, employee name, and position. The temperature should be taken and recorded by the screener in a fourth column in the log book. Employee screenings would not require documentation on an employee screening form, unless the employee responds "YES" to any question in section 1 or 2, responds "NO" to section 3, or has a temperature of 100.0°F or above. Only positive screens that would deny clearance into the facility require completion of the employee screening form. All cleared employees would only complete the log book (see example spreadsheet below).

DATE	EMPLOYEE NAME	POSITION	TEMPERATURE

- A temperature should also be taken ideally with a no-touch infrared thermometer. Refer to Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic for information on proper thermometer usage and factors that could impact thermometer readings.
- Screening is generally performed by non-health care personnel.
- Positive screens require notification of the Watch Commander and the employee's immediate supervisor for civilian staff.
- All actions should adhere to the most recent version of the Department of Human Resources Development instructions for "2019 Novel Coronavirus (COVID-19): Questions and Answers for Supervisors and Managers," currently Version #6.
- Employees who screen positive for symptoms should be sent home and advised to consult their healthcare provider.
- Employees, who are COVID-19 close contacts, should get tested 3-5 days after exposure to someone with suspected or confirmed COVID-19, consult their healthcare provider, self-monitor for symptoms and, if feasible, self-quarantine for 14 days (see 3 Key Steps to Take While Waiting for Your COVID-19 Test Result and Contact Tracing). According to the CDC, "The best way to protect incarcerated/detained persons, staff, and visitors is to quarantine for 14 days." As an alternative to the 14-day quarantine period for identified close contacts who do not reside in a correctional facility, HDOH adopted the CDC option to shorten the quarantine period to 10 days, ONLY if the following criteria are met:
  - No clinical evidence of COVID-19 has been elicited by daily symptom monitoring during the quarantine period, up to the time quarantine is discontinued;
  - Self-monitoring for symptoms of COVID-19 illness for a full 14 days after the last date of exposure;
  - Close contacts who develop symptoms within 14 days of the last exposure should be tested for COVID-19 and self-isolate while awaiting results; **AND**
  - Close contacts are informed to strictly adhere to all recommended mitigation strategies, including:
    - Correct and consistent mask use
    - Physical distancing
    - Hand and cough hygiene
    - Avoiding crowds
    - Environmental cleaning and disinfection
    - Ensuring adequate indoor ventilation
- Employees, who have recovered from confirmed COVID-19 illness within the previous 3 months and remain without COVID-19 symptoms, do NOT require quarantine if exposed to someone with COVID-19.

- The fully vaccinated employee, who is identified as a COVID-19 close contact, does not require quarantine and may continue to report to work if no symptoms have been experienced since exposure and the employee remains asymptomatic. HDOH recommends that employers who exempt vaccinated employees from quarantine only accept written, dated records as evidence of vaccination (see Sample Letter). Employees who do not produce written documentation of vaccination(s) are subject to quarantine requirements. The fully vaccinated employee should get tested 3-5 days after exposure to someone with suspected or confirmed COVID-19, consult their healthcare provider (people who have a condition or are taking medication that weaken the immune system may not be protected), self-monitor for symptoms, and strictly adhere to the mitigation strategies for close contacts detailed above. Symptomatic employees should be sent home. Note: in general, people are considered fully vaccinated two weeks after the second dose in a 2-dose series or two weeks after a single dose vaccine.
- If the fully vaccinated employee has a medical condition or is taking medication that weakens the immune system, the employee may NOT be protected and should continue to take all precautions recommended for unvaccinated people until advised otherwise by a healthcare provider.
- As a last resort and only in limited circumstances when it is necessary to preserve the function of critical infrastructure workplaces (e.g., when cessation of operation of a facility may cause serious harm or danger to public health or safety), the facility Warden or Administrator, in collaboration with HDOH, may consider allowing an exposed and asymptomatic critical infrastructure worker (e.g., adult correctional officers, law enforcement officers, and healthcare workers), to continue to work following exposure to a person with suspected or confirmed COVID-19 provided the employee remain asymptomatic and has not tested positive.

  Additionally, the following risk mitigation precautions should be implemented to protect the critical infrastructure worker and others prior to and during the work shift:

  - Pre-Screen: The employee should self-screen at home prior to arriving onsite. The employee should not attempt to enter the workplace if any of the following are present: symptoms of COVID-19; temperature equal to or higher than 100.0 °F; or are waiting for the results of a viral test.
  - Screen at the Workplace: Before the employee enters the facility, employers should conduct an on-site symptom assessment, including temperature screening, prior to each work shift.
  - Regular Monitoring: Under supervision, the employee should self-monitor and report to the supervisor the development of a temperature or other symptoms. To the extent possible, complete the self-monitoring form for asymptomatic workers with low risk exposure or the active monitoring form for asymptomatic workers with high risk exposure (see also Flowchart for management of HCWs with exposure to a person with COVID-19).
  - Wear a Mask: The employee should wear a mask (unless contraindicated) at all times while in the workplace for 14 days after the last exposure and/or in accordance with CDC and OSHA guidance and any state or local requirements.
  - Social Distance: The employee should maintain 6 feet of physical distance from others and practice social distancing as work duties permit in the workplace.
  - Disinfect and Clean Workspaces: Continue enhanced cleaning and disinfecting practices in all areas, especially frequently touched surfaces and objects, including offices, bathrooms, common areas, and shared equipment (refer to CDC Cleaning and Disinfecting Your Facility).

6. New Intake Screening

- New intakes should be provided masks (unless contraindicated) and screened for symptoms in accordance with established nursing protocols. Screening should take place in an outdoor space prior to entry, in the sally port, or at the point of entry into the facility immediately upon entry (weather, security protocols, and logistics permitting), before beginning the intake process.
- Temperature should be taken, ideally with an infrared no-touch thermometer with staff wearing PPE as described in Element #3f.
- Additional questions should be asked regarding travel history and potential exposure to COVID-19.
- New inmate arrivals should be separated from other inmates until the screening process has been completed.
- If new intakes are identified with symptoms then ***immediately place a mask (unless contraindicated) on the inmate,*** have the inmate perform hand hygiene, and place the inmate in a separate room, preferably with a toilet, while determining next steps. If no mask is immediately available, instruct the inmate to cover mouth/nose with cotton/cotton-blended shirt, towel, or pillowcase until a mask is available. Staff entering the room shall wear personal protective equipment (PPE) in accordance with guidance in Element #8.
- Identify inmates who were transferred with the symptomatic new intake for the need to quarantine (see Element #12).
- If new intakes report history of exposure to COVID-19, then they should be placed in quarantine (see Element #12).
- To the extent possible, implement routine intake quarantine (i.e., quarantine all new admissions to the facility, including inmates returning after more than 24 hours away from the facility, for 14 days before housing such inmates in the general population). Inmates in routine intake quarantine should be housed separately from inmates who are quarantined due to contact with a suspected or confirmed COVID-19 case, if possible.
- Inmates, who are fully vaccinated and do not have symptoms consistent with COVID-19, may be released from routine intake quarantine upon confirmation of the fully vaccinated status and a negative viral test for SARS-CoV-2.
- Inmates, who have recovered from confirmed COVID-19 illness within the previous 3 months and remain without COVID-19 symptoms, do NOT require quarantine or routine intake quarantine.

7. Initial Management and Testing of SARS-CoV-2

- **Source control (placing a mask on a potentially infectious person) is critically important.** If an inmate is identified with COVID-19 symptoms, then *immediately place a mask on the inmate (unless contraindicated)* and have the inmate perform hand hygiene.
- Place the inmate in a separate room, preferably with a toilet and sink, while determining next steps. Contact should be minimized to the extent possible until the symptomatic inmate is wearing a mask (unless contraindicated) and staff are wearing personal protective equipment (PPE) as outlined in Element #8.
- The CDC provides an Overview of Testing for SARS-CoV-2, Testing Strategies for SARS-CoV-2, Guidance for Healthcare Workers about COVID-19 (SARS-CoV-2) Testing, and Interim Guidance for SARS-CoV-2 Testing in Correctional and Detention Facilities. Decisions about how to manage and test inmates for SARS-CoV-2 should be made in collaboration with the facility Provider or Medical Director and the Hawaii Department of Health. Test strategy implementation should be guided by what is feasible, practical, and acceptable, and should be tailored to the needs at each facility.
- Viral tests, including Nucleic Acid Amplification Tests (NAATs) and antigen tests are used as diagnostic tests to detect infection. The "gold standard" for clinical diagnostic detection of SARS-CoV-2 remains the real-time reverse transcription-polymerase chain reaction (RT-PCR), which are high sensitivity, high specificity NAATs for diagnosing SARS-CoV-2 infection. Antigen tests are immunoassays that detect the presence of a specific viral antigen. Because of the performance characteristics of antigen tests, use of the Antigen Testing Algorithm is recommended to determine when confirmatory NAAT testing is needed. The CDC provides Guidance for SARS-CoV-2 Point-of-Care and Rapid Testing and Interim Guidance for Antigen Testing for SARS-CoV-2. The Food and Drug Administration (FDA)
- Viral testing is recommended for inmates with signs or symptoms consistent with COVID-19 and all close contacts of persons with SARS-CoV-2 infection. Decisions on screening testing asymptomatic inmates without known or suspected SARS-CoV-2 exposure (e.g., testing in routine intake quarantine prior to rehousing in the general population, pre-release testing if released to a congregate setting or to a household with persons at increased risk for severe illness from COVID-19), should be based on an assessment of the unique situation in each facility and the testing requirements for certain pre-medical procedures (e.g., see Interim SARS-CoV-2 Testing Guidelines for Patients in Outpatient Hemodialysis Facilities), as determined by the Medical Director in consultation with the Hawaii Department of Health. The CDC does not recommend using antibody testing for diagnosing current infection (see the CDC Interim Guidelines for COVID-19 Antibody Testing). Antibody tests are used to detect past infection with SARS-CoV-2 and can aid in the diagnosis of Multisystem Inflammatory Syndrome. It is not currently known whether a positive antibody test result indicates immunity against SARS-CoV-2; therefore, at this time, antibody tests should not be used to determine if an inmate is immune against reinfection.
- Inmates infected with SARS-CoV-2 can have another viral (e.g., influenza), bacterial, or fungal infection at the same time. During widespread cocirculation of SARS-CoV-2 and influenza, including during the off season, the CDC recommends clinicians consider multipathogen testing.

- The CDC provides considerations for jails and prisons when Performing Broad-Based Testing for SARS-CoV-2 in Congregate Correctional, Detention, and Homeless Service Settings, including needed supplies, planning, physical space, protocol for testing multiple inmates in succession, staff assignments, and post-test tasks (see also the CDC Interim Guidance for SARS-CoV-2 Testing in Correctional and Detention Facilities). In addition to testing inmates, consider strategies for screening testing asymptomatic staff without known SARS-CoV-2 exposure for early identification of SARS-CoV-2 in the facility. The CDC provides Interim Guidance on Testing Healthcare Personnel for SARS-CoV-2, Interim Guidance for SARS-CoV-2 Testing in Non-Healthcare Workplaces, Workplace SARS-CoV-2 Testing: Consent Elements and Disclosures, and Testing Strategy for Coronavirus (COVID-19) in High-Density Critical Infrastructure Workplaces after a COVID-19 Case is Identified. If offering testing to staff, follow the guidance from the Equal Employment Opportunity Commission. Refer to the Occupational Safety and Health Administration for compliance with 29 CFR Part 1904 with respect to COVID-19 occupational illness recording requirements.
- For additional testing information, see the CDC Interim Guidelines for Collecting and Handling of Clinical Specimens for COVID-19 Testing, CDC Diagnostic Tests for COVID-19, Interim Laboratory Biosafety Guidelines for Handling and Processing Specimens Associated with Coronavirus Disease 2019 (COVID-19), Guidance for SARS-CoV-2 Point-of-Care and Rapid Testing, and How to Report COVID-19 Laboratory Data.
- Nasopharyngeal swabbing should only be performed by staff with demonstrated competency. See instructional video at: https://www.youtube.com/watch?v=DVJNWefmHjE.
- Suspend co-pays for inmates seeking medical evaluation for possible COVID-19 symptoms.

8. Personal Protective Equipment (PPE)

Table 2. Definitions of "Surgical Masks" and "Respirators"

***Surgical Masks*:** Disposable FDA-approved masks, which come in various shapes and types (e.g., flat with nose bridge and ties, duck billed, flat and pleated, pre-molded with elastic bands). If surgical masks are in short supply, use temporary alternative methods of source control, such as the use of cloth masks.

Respirators: N-95 or higher filtering, face-piece respirators that are certified by CDC/NIOSH.

- The CDC recommends the following Personal Protective Equipment (PPE) when an individual encounters a person with suspected or confirmed COVID-19.
  - **N95 Respirator**.
    - N95 respirators should be prioritized when staff anticipate contact with infectious aerosols or droplets from someone with COVID-19. Individuals working under conditions that require an N95 respirator should not use a cloth mask when an N95 is indicated.

- Through the established respiratory protection program, ensure that staff and inmates who require respiratory protection for work responsibilities have been medically cleared, trained, and fit-tested as appropriate.
- N95 respirators should not be worn with facial hair that interferes with the respirator seal.
- If N95 respirators are to be used, they must be used in the context of a fit-testing program. Fit testing is specific to the brand/size of respirator to be used.
- Perform User Seal Check prior to every use to ensure an adequate seal is achieved (see also Respirator On/Respirator Off).

○ **Surgical Mask**.

- Worn to protect the wearer from splashes, sprays, and respiratory droplets generated by others. Note: Surgical masks are distinct from masks (i.e., cloth-type), which are not PPE but are worn to protect others in the surrounding area from respiratory droplets generated by the wearer. Individuals working under conditions that require a surgical mask should use a surgical mask, not a cloth mask.
- A surgical mask can be layered underneath a cloth mask for improved fit and filtration. However, a surgical mask should not be layered underneath a second surgical mask. Use of a mask fitter or brace may help to improve fit.

○ **Eye Protection** (goggles or disposable face shield that fully covers the front and sides of the face).

- This does not include personal eyeglasses.
- If reusable eye protection is used, it should be cleaned and disinfected in accordance with the manufacturer's instructions.

○ **Gloves**.

- Disposable examination gloves should be changed if torn or heavily contaminated.

○ **Gown/One-Piece Coverall**.

- If security staff are unable to wear a disposable gown or coverall due to limitations in access to the duty belt and gear, then the duty belt and gear should be disinfected after close contact with an inmate with confirmed or suspected COVID-19. Clothing should be changed as soon as possible. Clean and disinfect duty belt and gear prior to reuse.
- If gowns/one-piece coveralls are in short supply, prioritize for aerosol-generating procedures and high contact activities that provide opportunities for transfer of pathogens to the hands and clothing of the wearer.

▪ Train staff and inmates, who will have contact with infectious materials, to correctly don, doff, and dispose of PPE relevant to the level of contact anticipated with individuals with confirmed and suspected COVID-19. See CDC instructions on donning (putting on) and doffing (removing) PPE: Comprehensive PPE Training Videos , Using Personal Protective Equipment (PPE), PPE Sequence Poster, Use Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID-19, and Protecting Healthcare Personnel. Ensure strict adherence to OSHA PPE standards.

▪ It is strongly emphasized that hand hygiene be performed before donning and after doffing PPE.

- Designate PPE donning/doffing stations outside all spaces where PPE will be used. PPE stations should include a dedicated trash can for disposal of used PPE, a hand washing station or access to alcohol-based hand sanitizer, and a PPE Sequence Poster for donning and doffing.
- Ensure PPE is readily available where and when needed.
- Inventory current supplies of PPE and implement plans for restocking PPE as needed (see Personal Protective Equipment (PPE) Burn Rate Calculator (Version 2)).
- Develop contingency plans for PPE shortages during the COVID-19 pandemic. The CDC notes that PPE shortages are anticipated in every category during the COVID-19 response. Refer to the CDC Strategies to Optimize the Supply of PPE and Equipment and Summary for Healthcare Facilities: Strategies for Optimizing the Supply of PPE during Shortages (see also N95 and Other Respirators, Summary for Healthcare Facilities: Strategies for Optimizing the Supply of N95 Respirators during Shortages, and Implementing Filtering Facepiece Respirator (FFR) Reuse, Including Reuse after Decontamination, When There Are Known Shortages of N95 Respirators).
- Criteria for using various types of PPE based on the type of contact is outlined in Table 3.
- The CDC identifies PPE as one of many examples of risk factors for heat-related illness. Heat stroke, the most severe form of heat-related illness, is a life-threatening medical emergency.

  Early signs of heat stroke may include:

  - Confusion
  - Difficulty performing routine tasks or answering simple questions, like "What is today's date?" or "Where are we?"
  - Slurred speech

  Late signs of heat stroke may include:

  - Seizures
  - Loss of consciousness
  - Organ failure resulting in death

  The CDC provides guidance on how to reduce the risk for heat-related illness during the COVID-19 pandemic (see What Workers Need to Know about Heat Stress Prevention during the COVID-19 Pandemic and Employer Information for Heat Stress Prevention during the COVID-19 Pandemic).
- Other Supplies
  - Standard medical supplies and pharmaceuticals for daily clinic needs
  - Liquid or foam soap when possible; If bar soap is used, ensure that it does not irritate the skin and thereby discourage frequent hand washing; Ensure a sufficient supply of soap for each individual
  - Hand drying supplies
  - Tissues
  - Alcohol-based hand sanitizer containing at least 60% alcohol (where permissible)
  - Cleaning supplies, including EPA-registered disinfectants effective against SARS-CoV-2, the virus that causes COVID-19
  - Sterile viral transport media and sterile swabs to collect nasopharyngeal specimens if COVID-19 testing is indicated

Table 3. COVID-19 Personal Protective Equipment Recommendations					
Situation	**N95 respirator**	**Surgical mask**	**Eye protection**	**Gloves**	**Gown/ coveralls**
STAFF					
Staff performing routine screening and temperature checks on: employees, visitors/vendors/volunteers, or inmates		X	X	X	
Medical Isolation: Staff providing medical care for suspected/confirmed COVID-19 cases (including testing)	X [1]		X	X	X
Medical Isolation: Correctional staff entering isolation room	X [1]		X	X	X
Staff present during aerosolizing procedure on suspected or confirmed COVID-19 case	X		X	X	X
Staff handling laundry (from a COVID-19 case or close contact)				X	X
Staff handling used food service items (from a COVID-19 case or close contact)				X	X
Staff cleaning an area (where a COVID-19 case has spent time)	*Additional PPE may be needed based on the product label.*			X	X
Transport of suspected/confirmed COVID-19	X [1]		*During transport*		
Prior to & following transport (if in close contact)	X [1]		X	X	X
Quarantine: Direct contact with asymptomatic persons (including medical care/temperature checks)	X [1]		X	X	
Quarantine: Direct contact with asymptomatic persons (but not performing temperature checks or providing medical care) or no direct contact with asymptomatic persons who are close contacts to COVID-19		*Surgical mask [1], eye protection and gloves as local supply and scope of duties allow.*			
INCARCERATED/DETAINED PERSONS					
Confirmed or suspected COVID-19 cases, or showing symptoms of COVID-19	*Use masks for source control [2]*				
Quarantine: Asymptomatic COVID-19 close contacts					
Laundry worker (handling items from COVID-19 case or close contact)				X	X
Food service worker (handling items from COVID-19 case or close contact)				X	X
Worker performing cleaning (areas where COVID-19 case has spent time)	*Additional PPE may be needed based on the product label.*			X	X

1 A NIOSH-approved N95 respirator is preferred. However, based on local situational analysis of PPE supplies, surgical masks may be an acceptable alternative when the supply chain of respirators cannot meet the demand. During this time, available respirators should be prioritized for procedures that are likely to generate respiratory aerosols, which would pose the highest exposure risk to staff.

2 Masks (i.e., cloth-type) are NOT PPE and may not protect the wearer. Prioritize PPE for source control among all persons who do not meet criteria for N95 or surgical masks, and to conserve surgical masks for situations that require PPE.

Adapted from: CDC. Interim Guidance on Management of COVID-19 in Correctional and Detention Facilities (Table 1); 06/09/21. Available at: https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html#Min_Mod_Trans

9. Transport

Depending on the degree of local community transmission, postpone non-essential inmate transports. Prior to transporting inmates to outside appointments and transferring inmates between other jurisdictions and facilities, procedures should be established to ensure screening is conducted by nursing. Positive screens should remain at the sending facility until cleared by the Provider. To the extent possible, inmates transported outside the facility must wear masks (unless contraindicated). Prior to a transfer to another correctional facility, ensure that the receiving facility has capacity to properly quarantine or medically isolate the inmate upon arrival.

To the extent possible, implement routine transport quarantine (i.e., quarantine of all inmates, who enter the facility by outside transport, for 14 days before housed in the general population). Inmates in routine transport quarantine should be housed separately from inmates who are quarantined due to contact with suspected or confirmed COVID-19 case(s).

Fully vaccinated inmates, who are transferred between correctional facilities or between a correctional facility and another congregate setting (e.g., Hawaii State Hospital), and do not have symptoms consistent with COVID-19, may be released from routine transport quarantine upon confirmation of the fully vaccinated status and a negative viral test for SARS-CoV-2. Fully vaccinated inmates, who are transported to outside appointments (e.g., court, medical care), and do not have symptoms consistent with COVID-19, do NOT require routine transport quarantine or SARS-CoV-2 testing upon return to the facility. Inmates, who have recovered from confirmed COVID-19 illness within the previous 3 months and remain without COVID-19 symptoms, do NOT require routine transport quarantine and should not be tested for SARS-CoV-2.

Refer to the CDC guidance for Emergency Medical Services on safely transporting inmates with confirmed or suspected COVID-19. If a decision is made to transport a patient with confirmed or suspected COVID-19, or a quarantined close contact, to a health care facility and the transport vehicle is not equipped with the features described in the EMS guidance, the following transport considerations should be followed at a minimum.

- Notify the receiving health care facility of the pending transport of a potentially infectious patient.
- Patient wears a mask (unless contraindicated) and performs hand hygiene.
- Transporting officer wears recommended PPE, depending on local situational analysis of PPE supplies: preferably N-95 respirator, gloves, gown, and eye protection if in close contact with inmate prior to transport. Note: when accompanying EMS in ambulance, transporting officer should use recommended PPE for aerosolizing procedures.
- Prior to transporting, all PPE (except for surgical mask or N-95) is removed and hand hygiene is performed. This is to prevent contaminating the driving compartment.
- Ventilation system should bring in as much outdoor air as possible. Set fan to high. If the vehicle has a ceiling hatch, keep it open.
- Do NOT place air on recirculation mode.

- Weather permitting, drive with the windows down.
- Following the transport, if close contact with the patient is anticipated, put on a new set of PPE. Perform hand hygiene after PPE is removed.
- After transporting a patient, air out the vehicle for one hour before using it without a mask.
- When cleaning the vehicle, wear a disposable gown and gloves. A mask and a face shield or goggles should be worn if splashes or sprays during cleaning are anticipated.
- Clean and disinfect the vehicle after the transport utilizing instructions in Element #3b.

10. Medical Isolation / Cohorting (*Symptomatic Persons*)

Table 4. Definitions of "Medical Isolation" and "Quarantine"
Medical Isolation: refers to the procedure of separating someone with confirmed or suspected COVID-19 infection (i.e., those who are sick with COVID-19 symptoms and those with no symptoms), from others who are not infected.
Quarantine: refers to the procedure of separating people who might have been exposed to COVID-19 from others.

A critical infection control measure for COVID-19 is to promptly separate inmates with confirmed or suspected COVID-19 infection (i.e., those who are sick with COVID-19 symptoms and those with no symptoms), from other inmates who are not infected. Medical isolation is a non-punitive medical intervention. To the extent possible, the conditions in medical isolation should be distinct from those in disciplinary segregation. While cohorting inmates with laboratory confirmed COVID-19 is acceptable, cohorting inmates with suspected COVID-19 is not recommended due to the high risk of transmission from infected to uninfected inmates. Inmates with laboratory confirmed COVID-19 should be housed separately from those with undiagnosed respiratory illness.

- The CDC provides guidance for housing individuals under medical isolation (refer to Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities). Facilities without sufficient space to implement effective medical isolation should coordinate with the Hawaii Department of Health to ensure that COVID-19 cases will be appropriately managed.
- To minimize the likelihood of disease transmission, inmates who are medically isolated or cohorted should wear a mask (unless contraindicated). Masks should be replaced as needed. Inmates who are cohorted with undiagnosed respiratory illness should wear a mask (unless contraindicated) to protect inmates with respiratory illnesses other than COVID-19.
- Facilities should ensure that medical isolation is operationally distinct from disciplinary segregation to the extent possible, even if the same housing spaces are used for both. To avoid being placed in punitive housing conditions, inmates may be hesitant to report COVID-19 symptoms, leading to continued transmission within shared housing spaces and, potentially, lack of health care and adverse health outcomes for infected inmates who delay reporting symptoms.

For example:

- Ensure that inmates under medical isolation receive regular visits from medical staff and have access to mental health services.
- Make efforts to provide similar access to radio, television, reading materials, personal property, and commissary, as would be available in regular housing units, if possible.
- Consider allowing increased telephone privileges without a cost barrier to maintain mental health and connection with others while medically isolated, where possible.
- Communicate regularly with medically isolated inmates about the duration and purpose of the medical isolation period.

- Medical isolation cells or rooms should be identified with the Respiratory Infection Isolation Room Precautions sign (see Attachment 5) and relevant CDC Transmission-Based Precautions sign(s) (e.g., Contact Precautions and Droplet Precautions). See Attachment 3 and Attachment 4.
- The door to the Medical Isolation Cell should always remain closed, except when staff must enter and exit the cell, or when the medically isolated inmate must enter and exit the cell for treatment or bathroom use.
- Keep the inmate's movement outside the medical isolation space to an absolute minimum.
  - Provide medical care to medically isolated inmates inside the medical isolation space, unless they need to be transferred to a healthcare facility.
  - Dedicated medical equipment (e.g., blood pressure cuffs), should be left in room (ideally) or decontaminated in accordance with manufacturer's instructions.
  - Serve meals inside the medical isolation space. Inmates in medical isolation should throw disposable food service items in regular trash in the medical isolation room. Non-disposable food service items should be handled with gloves and washed with hot water or in a dishwasher. Individuals handling food service items should clean their hands after removing gloves.
  - Exclude the inmate from all group activities.
  - Provide inmates in medical isolation with tissues, and if permissible and available, a lined no-touch trash receptacle. Instruct inmates to:
    - Cover their mouth and nose with a tissue when they cough or sneeze.
    - Dispose of used tissues immediately in the lined trash receptacle.
    - Wash hands immediately with soap and water for at least 20 seconds.
  - Laundry should be transported from the medical isolation area to the laundering location in a bag liner that is either disposable or can be laundered. Individuals handling laundry from COVID-19 cases should wear disposable gloves and gown, discard after each use, and perform hand hygiene. Do not shake dirty laundry (to minimize the possibility of dispersing virus through the air). Laundry from COVID-19 cases may be washed with other inmate laundry. Use the hottest appropriate water setting and dry items completely. Clean and disinfect clothes hampers in accordance with Element 3b.
  - Ideally, the Medical Isolation unit should have a dedicated bathroom attached. If not, inmates must wear a mask (unless contraindicated) to go to the bathroom outside the room.

When a dedicated bathroom is not feasible, do not reduce access to restroom or shower use as a result. Clean and disinfect areas used by infected inmates frequently on an ongoing basis during medical isolation.

- If inmates with respiratory illness must be taken out of the medical isolation room, they should wear a mask (unless contraindicated) and perform hand hygiene before leaving the room.
- If an inmate who is in medical isolation must undergo a procedure that is likely to generate aerosols (e.g., suctioning, administering nebulized medication, testing for COVID-19), they should be placed in a separate room. An N95 respirator (not a surgical mask), gloves, gown, and face protection should be used by staff.
- If the facility is housing inmates with confirmed COVID-19 as a cohort:
  - Only inmates with laboratory-confirmed COVID-19 should be placed under medical isolation as a cohort. Do not cohort inmates who have confirmed COVID-19 with other inmates who have suspected COVID-19, who are close contacts of individuals with confirmed or suspected COVID-19, or who have an undiagnosed respiratory infection that does meet the criteria for suspected COVID-19.
  - Use a well-ventilated room with solid walls and a solid door that closes fully, where possible.
  - To conserve PPE and reduce the risk of cross-contamination across different parts of the facility, consider using one large space for cohorted inmates with confirmed COVID-19 on medical isolation status. Depending on the degree and severity of illness among inmates, bunk beds may or may not be suitable.
- If feasible, designated security staff should be assigned to monitor medically isolated inmates in order to minimize exposures. If an inmate has laboratory-confirmed COVID-19, staff should maintain a consistent duty assignment in the same area of the facility across shifts to prevent transmission across different facility areas, where possible. Staff assigned to medical isolation posts should limit their movement to other parts of the facility as much as possible. If staff must serve multiple areas of the facility, ensure staff change PPE when leaving the medical isolation space. If PPE supplies necessitate reuse, staff should move from areas of low to high exposure risk (e.g., start in a housing unit where no one is known to be infected, then move to a space used as quarantine for close contacts, and end in a medical isolation unit).
- When feasible and consistent with security priorities, encourage staff to maintain a distance of 6 feet or more from an inmate with COVID-19 symptoms while interviewing, escorting, or interacting in other ways. Keep interactions with inmates with COVID-19 symptoms as brief as possible.
- Admission to and Discharge from Medical Isolation must be ordered by a Provider.
  - If an inmate with suspected COVID-19 receives a positive SARS-CoV-2 test, continue medical isolation until discharged by the Provider.
  - If an inmate with suspected COVID-19 receives a negative SARS-CoV-2 test and the inmate is discharged from Medical Isolation by the Provider, the inmate may be returned to general population housing unless the inmate requires quarantine as a close contact of someone with COVID-19 or the inmate requires completion of the 14-day Routine Intake Quarantine.

Table 5. CDC Levels of Illness Severity
Mild Illness: Individuals who have any of the various signs and symptoms of COVID-19 (e.g., fever, cough, sore throat, malaise, headache, muscle pain) without shortness of breath, dyspnea, or abnormal chest imaging). **Moderate Illness**: Individuals who have evidence of lower respiratory disease by clinical assessment or imaging, and a saturation of oxygen (SpO2) ≥ 94% on room air at sea level. **Severe Illness**: Individuals who have respiratory frequency > 30 breaths per minute, SpO2 < 94% on room air at sea level (or, for individuals with chronic hypoxemia, a decrease from baseline of > 3%), ratio of arterial partial pressure of oxygen to fraction of inspired oxygen (PaO2/FiO2) < 300 mmHg, or lung infiltrates > 50%. **Critical Illness**: Individuals who have respiratory failure, septic shock, and/or multiple organ dysfunction. **Note: The highest level of illness severity experienced at any point in the clinical course should be used when determining the duration of transmission-based precautions**.

- The CDC recommended strategy for discontinuing medical isolation and transmission-based precautions are expected to change as additional data on Duration of Isolation and Precautions for Adults with COVID-19 become available. Providers should review the CDC guidance cited above and HDOH Medical Advisories for rapidly changing updates. Except for rare situations, CDC and HDOH no longer recommend a test-based strategy for confirmed COVID-19. At this time, CDC and HDOH recommend the following symptom-based strategy for discontinuation of transmission-based precautions for confirmed COVID-19.
  - Inmates, who experienced *mild to moderate illness* and *are not severely immunocompromised*:
    - At least 10 days have passed since symptoms first appeared; **AND**
    - At least 24 hours have passed since last fever without the use of fever-reducing medications; **AND**
    - Symptoms (e.g., cough, shortness of breath), have improved*

      * Loss of taste and sense of smell may persist for weeks or months after recovery and need not delay the end of medical isolation.
  - Inmates, who were *asymptomatic* throughout the infection and are not *severely immunocompromised*:
    - At least 10 days have passed since the date of collection of the first positive viral diagnostic test
  - Inmates, who experienced *severe to critical illness* or who *are severely immunocompromised* (consultation with an infectious disease specialist is recommended):
    - At least 10 days and up to 20 days have passed since symptoms first appeared; **AND**
    - At least 24 hours have passed since last fever without the use of fever-reducing medications; **AND**
    - Symptoms (e.g., cough, shortness of breath), have improved

- Inmates, who were *asymptomatic* throughout the infection and are *severely immunocompromised* (consultation with an infectious disease specialist is recommended):
  - At least 10 days and up to 20 days have passed since the date of collection of the first positive viral diagnostic test

  Note: Some adults with severe illness may produce replication-competent virus beyond 10 days that may warrant extending duration of isolation and precautions for up to 20 days after symptom onset; severely immunocompromised patients (e.g., being on chemotherapy for cancer, hematologic malignancies, being within one year out from receiving a hematopoietic stem cell or solid organ transplant, untreated HIV infection with CD4 T lymphocyte count <200, combined primary immunodeficiency disorder, and taking immunosuppressive medications (e.g., drugs to suppress rejection of transplanted organs or to treat rheumatologic conditions such as mycophenolate and rituximab, receipt of prednisone >20mg/day for more than 14 days)), may produce replication-competent virus beyond 20 days and require additional testing and consultation with infectious diseases specialists and infection control experts. Other factors, such as advanced age, diabetes mellitus, or end-stage renal disease, may pose a much lower degree of immunocompromise. Ultimately, the degree of immunocompromise for the patient is determined by the treating provider, and preventive actions should be tailored to each patient.

- According to the CDC, the above guidance on medical isolation does not imply immunity to COVID-19.
  - People who have recovered from COVID-19 may have low levels of virus detectable for up to 3 months after diagnosis. This means that if the person, who has recovered from COVID-19, is retested within 3 months of initial infection, the person may continue to have a positive test result, even though the person may not be spreading COVID-19.
  - To date, reinfection appears to be uncommon during the initial 90 days after symptom onset of the preceding infection; however, research is ongoing (see Reinfection with COVID-19). Persons infected with related endemic human betacoronavirus appear to become susceptible again at around 90 days after onset of infection. Thus, for persons recovered from SARS-CoV-2 infection, a positive PCR during the 90 days after illness onset more likely represents persistent shedding of viral RNA than reinfection.
  - If an inmate has a new exposure to someone with suspected or confirmed COVID-19 and:
    - Has recovered from illness due to laboratory-confirmed SARS-CoV-2 infection and has already met criteria to end isolation, and
    - Is within the first 90 days following the onset of symptoms of their initial laboratory-confirmed SARS-CoV-2 infection or within the first 90 days of their first positive SARS-CoV-2 test result if they were asymptomatic during initial infection, and
    - Has remained asymptomatic since the new exposure, then the inmate does not require repeat testing or quarantine for SARS-CoV-2 in the context of the new exposure.

- If an inmate has a new exposure to a person with suspected or confirmed COVID-19 and meets the first two above criteria, but has or develops new symptoms consistent with COVID-19 within 14 days of the new exposure, consultation with a health care provider is recommended, and consultation with infectious disease or infection control experts may be necessary. If an alternative cause of the symptoms (e.g., influenza), cannot be readily identified, retesting for SARS-CoV-2 infection may be warranted. Medical isolation is recommended during the evaluation and until the inmate meets criteria for discontinuation of transmission-based precautions.

- If an inmate with suspected or confirmed COVID-19 is to be released from the facility before discharge from medical isolation, notify the Hawaii Department of Health to provide direct linkage to community resources and release planning (e.g., transport, shelter, and medical care).
- If an inmate on medical isolation status is scheduled to transfer to the Hawaii State Hospital or another correctional facility, hold the transfer until the inmate is cleared for transfer by the Medical Director.
- After an inmate with COVID-19 is discharged from medical isolation, close off the area. If possible, open outside doors and windows and use fans or HVAC to increase air circulation in the area. Wait as long as practical, up to 24 hours under the poorest air exchange conditions (consult CDC Guidelines for Environmental Infection Control in Health-Care Facilities for wait time based on different ventilation conditions) before beginning to clean and disinfect. Ensure that persons cleaning the area wear recommended PPE for medical isolation (see Table 3). Thoroughly clean and disinfect utilizing instructions in Element #3b with an emphasis on frequently touched surfaces.

  Vacuum the space, if needed, using high-efficiency particulate air (HEPA) filter and bags. While vacuuming, temporarily turn off in-room, window-mounted, or on-wall recirculation heating, ventilation, and air conditioning systems to avoid contamination of HVAC units. Do not deactivate central HVAC systems, which provide better filtration capabilities and introduce outdoor air into the areas serviced.

11. Care for the Sick

- Staff evaluating and providing care for COVID-19 cases should review the CDC Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease (COVID-19) and the National Institutes of Health Coronavirus Disease 2019 (COVID-19) Treatment Guidelines. Monitor the guidance and the CDC COVID-19 Published Science and Research websites regularly for updates to the recommendations.
- Two main processes are thought to drive the pathogenesis of COVID-19. Early in the course of the infection, the disease is primarily driven by replication of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). Later in the course of infection, the disease is driven by a dysregulated immune/inflammatory response to the virus that leads to tissue damage.

- Current clinical management of COVID-19 includes Core Infection Prevention and Control Practices and supportive care, including supplemental oxygen and mechanical ventilatory support when indicated. The U.S. Food and Drug Administration (FDA) has approved one drug, remdesivir (Veklury), for the treatment of COVID-19 in certain situations. The FDA has also issued emergency use authorization (EUA) to allow healthcare providers to use certain products that are not yet approved, or that are approved for other uses, to treat patients with COVID-19 if certain legal requirements are met.
- The recipe for oral rehydration solution is shown in Table 6 below.

Table 6. Oral Rehydration Solution Recipe
1-gallon clean water
10-tablespoons of sugar
4-teaspons salt
Directions: Stir up. Do not boil. Can add sugar-free drink mix to flavor. Use within 24 hours.

- Patients should be assessed at least twice daily for signs and symptoms of shortness of breath or decompensation.
- Clinicians should be aware of the potential for some patients to rapidly deteriorate 1 week after illness onset.
- The median time to acute respiratory distress syndrome (ARDS) ranges from 8 to 12 days.
- The facility should have a plan in place to safely transfer inmates with severe illness from COVID-19 to a local hospital if they require care beyond what the facility is able to provide.
- A low threshold should be used for making the decision to transport an inmate to the hospital if the inmate develops shortness of breath.
- Inmates diagnosed with COVID-19 should be evaluated and managed in chronic care clinic, as directed by the Provider. Inmates should be instructed to immediately notify the Medical Unit if experiencing any relapse of COVID-19 symptoms.
- The CDC is actively working to learn about the short- and long-term health effects associated with COVID-19. Although most people with COVID-19 get better within weeks of illness, some people experience Post-COVID Conditions, which include a wide range of new, returning, or ongoing health problems people can experience **four or more weeks** after initial infection with SARS-CoV-2. The CDC identifies three types of Post-COVID Conditions (see also Post-COVID Conditions: Information for Healthcare Providers and Evaluating and Caring for Patients with Post-COVID Conditions: Interim Guidance):
    - **New or Ongoing Symptoms** encompasses a range of symptoms and clinical findings that can last weeks or months after first being infected with the virus that causes COVID-19 or can appear weeks after infection. The most commonly reported persisting symptoms include:

- Dyspnea or increased respiratory effort
- Fatigue
- Post-exertional malaise (i.e., the worsening of symptoms following even minor physical or mental exertion, with symptoms typically worsening 12-48 hours after activity and lasting for days or weeks), and/or poor endurance
- "Brain fog" or cognitive impairment
- Cough
- Chest pain
- Headache
- Palpitations or tachycardia
- Arthralgia
- Myalgia
- Paresthesia
- Abdominal pain
- Diarrhea
- Insomnia and other sleep difficulties
- Fever
- Lightheadedness
- Impaired daily function and mobility
- Pain
- Rash (i.e., urticaria)
- Mood changes
- Anosmia or dysgeusia
- Menstrual cycle irregularities

- **Multiorgan Effects of COVID-19** can affect most, if not all, body systems including cardiovascular, pulmonary, renal, dermatologic, neurologic, and psychiatric. Multisystem inflammatory syndrome (MIS) and autoimmune conditions can also occur during and after COVID-19 infection. A wide variety of health effects can persist after the acute illness has resolved (e.g., pulmonary fibrosis, myocarditis). Some people who had severe illness with COVID-19 experience multiorgan effects or autoimmune conditions over a longer time with symptoms lasting weeks or months after COVID-19 illness.
- **Effects of COVID-19 Illness or Hospitalization** include some longer-term effects that are similar to those related to hospitalization for other respiratory infections or other conditions. This category can also encompass post-intensive care syndrome (PICS), which refers to health effects that remain after a critical illness (e.g., severe weakness, problems with thinking and judgement, and post-traumatic stress disorder).

- Inmates who are released while being treated for COVID-19 should be provided education about:
  - Steps to help prevent the spread of COVID-19 if you are sick
  - Symptoms of Coronavirus (COVID-19) and emergency warning signs (e.g., trouble breathing; persistent pain or pressure in the chest; new confusion; inability to wake or stay awake; and pale, gray, or blue-colored skin, lips, or bed nails, depending on skin tone), requiring immediate medical care.

12. Quarantine (*Asymptomatic Exposed Persons*)

The purpose of quarantine is to help prevent the spread of disease that can occur before a person knows they are sick or if they are infected with the virus without feeling symptoms. Quarantine is a medical intervention that separates inmates who might have been exposed to COVID-19 from others.

- In the context of COVID-19, a person is considered a Close Contact if the person has been within 6 feet of a confirmed COVID-19 case for a cumulative total of 15 minutes or more over a 24-hour period, starting from 48 hours before illness onset (or starting from 48 hours before the first positive test if asymptomatic) until the time the infected person meets criteria to end medical isolation; the person had direct physical contact (e.g., hugged, kissed), with a suspected or confirmed COVID-19 case; OR the person had direct contact with infectious secretions (e.g., sharing utensils, sneezed or coughed on), from a suspected or confirmed COVID-19 case. If a confirmed COVID-19 case is identified in an open dorm-style housing unit, all inmates living in the same housing unit should be considered a Close Contact.
- Refer to the Interim Guidance on Developing a COVID-19 Case Investigation and Contact Tracing Plan, Contact Tracing for COVID-19, Case Investigation and Contact Tracing in Non-healthcare Workplaces: Information for Employers, and Managing Investigations During an Outbreak for additional information on the use of Contact Tracing for the identification of Close Contacts in order to help contain disease outbreaks.
  - Contact tracing can be especially impactful when there is a small number of infected individuals in the facility or in a particular housing unit, when the infected individual had close contact with individuals from other housing units, and when the infected individual recently visited a community setting.
  - Contact tracing may be more feasible and effective in settings where inmates have limited contact with others (e.g., celled housing units), compared to settings where close contact is frequent and relatively uncontrolled (e.g., open dormitory housing units).
  - If there is a large number of individuals with COVID-19 in the facility, contact tracing may become difficult to manage. Under such conditions, consider broad-based testing in order to identify infections and prevent further transmission. The scope of broad-based testing should be based on the extent of inmate and staff movement between affected and unaffected areas of the facility.
- Viral testing is recommended for all close contacts of persons with SARS-CoV-2 infection.
  - Medically isolate those who test positive to prevent further transmission.
  - Asymptomatic close contacts testing negative should be placed under quarantine precautions for 14 days from their last exposure.
  - Re-test inmates in a quarantine cohort every 3-7 days to identify and medically isolate infected inmates early and minimize continued transmission within the cohort. To the extent possible, the testing interval should be based on the stage of an ongoing outbreak (e.g., testing every 3 days when transmission is escalating; testing every 5-7 days when transmission has slowed).

- Re-test inmates in a quarantine cohort on day 14 of the quarantine period. If all cohorted inmates test negative, quarantine precautions may be discontinued. If cohorted asymptomatic close contacts refuse SARS-CoV-2 testing on day 14, HDOH recommends extending the quarantine period to 28 days to account for transmission and incubation of the virus.

- Inmates who are close contacts of a suspected or confirmed COVID-19 case (i.e., other inmates, staff, visitors, vendors, volunteers), should be placed under quarantine for 14 days.
  - If an inmate is quarantined due to close contact with an individual who has laboratory confirmed COVID-19, but the quarantined inmate tests negative, the inmate should continue to quarantine for the full 14 days after last exposure and follow all recommendations of public health authorities. A negative COVID-19 test result could mean that the individual tested was likely not infected at the time the sample was collected or the specimen was inadequate. Persons with a negative COVID-19 test can develop infection at a later time.
  - If an inmate is quarantined due to close contact with a suspected COVID-19 individual who subsequently tests negative, the inmate may be considered for medical discharge from quarantine by the Provider. Due to the possibility of false negative results and other medical considerations involving the medically isolated inmate, only a Provider may order the discontinuation of quarantine.
  - Inmates, who have recovered from confirmed COVID-19 illness within the previous 3 months and remain without COVID-19 symptoms, do NOT require quarantine.
  - Inmates, who are fully vaccinated and do not have symptoms consistent with COVID-19 following exposure to someone with suspected or confirmed COVID-19, may be released from quarantine upon confirmation of the fully vaccinated status and a negative RT-PCR test for SARS-CoV-2. Fully vaccinated inmates released from quarantine under the above conditions must: a) continue to remain asymptomatic for COVID-19, b) continue to result negative on viral testing every 3-7 days and on day 14 since the last date of exposure to someone with suspected or confirmed COVID-19, and c) continue to wear a mask (unless contraindicated) while indoors through day 14 of the period since the last date of exposure to someone with suspected or confirmed COVID-19. Adherence to mask use is especially important if the inmate or someone in the inmate's cohort is immunocompromised, at increased risk for severe illness, or unvaccinated. Fully vaccinated inmates, who become infected with certain variants (e.g., Delta variant), of SARS-CoV-2, may be at risk for transmitting the virus to others.

- Facilities should make every effort to quarantine close contacts of an inmate with suspected or confirmed COVID-19 individually. Cohorting multiple close contacts in quarantine could result in the transmission of COVID-19 to inmates who are not infected. Cohorting should only be practiced if there are no other available options. Do not add more inmates to an existing quarantine cohort after the 14-day quarantine clock has started, if possible.
- The CDC provides guidance for housing multiple individuals under quarantine, in order of preference, (refer to Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities). If ideal quarantine housing is not available in a facility, use the next best alternative as a harm reduction approach.

- IDEAL: Separately, in single cells with solid walls (i.e., not bars), and solid doors that close fully.
- Separately, in single cells with solid walls, but without solid doors.
- As a cohort, in a large, well-ventilated cell with solid walls, a solid door that closes fully, and at least 6 feet of personal space assigned to each inmate in all directions.
- As a cohort, in a large, well-ventilated cell with solid walls and at least 6 feet of personal space assigned to each inmate in all directions, but without a solid door.
- As a cohort, in single cells without solid walls or solid doors (i.e., cells enclosed entirely with bars), preferably with an empty cell between occupied cells creating at least 6 feet of space between inmates. Note: Inmates are single-celled, but the airflow between cells essentially makes it a cohort arrangement in the context of COVID-19.
- As a cohort, in multi-person cells without solid walls or solid doors (i.e., cells enclosed entirely with bars), preferably with an empty cell between occupied cells. Employ social distancing strategies to maintain at least 6 feet of space between inmates housed in the same cell.
- As a cohort, in inmates' regularly assigned housing unit, but with no movement outside the unit (if an entire housing unit has been exposed – referred to as "quarantine in place"). Employ social distancing strategies to maintain at least 6 feet of space between inmates.
- Safely transfer to another facility with capacity to quarantine in one of the above arrangements. Note: Transfer should be avoided due to the potential to introduce infection to another facility; proceed only if no other options are available.

- Facilities without sufficient space to implement effective quarantine should consult with the Hawaii Department of Health (HDOH) to ensure that quarantine cases will be appropriately managed. The CDC provides Recommendations for Quarantine Duration in Correctional and Detention Facilities. In collaboration with HDOH, facilities considering a shortened quarantine duration should carefully weigh the risks of increased transmission and secondary clusters, and consider facility-specific characteristics (e.g., facility vaccination rate for employees and inmates, level of community transmission, ability to maintain social distancing, compliance with universal masking policies, ability to properly ventilate, proportion of employees and inmates at increased risk for severe illness from COVID-19, and availability of resources for broad-based testing, daily symptom screening, and outbreak response), before implementing a reduced quarantine alternative. Decisions to modify quarantine duration must be ordered by the Medical Director.
- The solid door (if available) to the Quarantine Room should remain closed. A sign should be placed on the door of the room indicating that it is a Quarantine Room, which lists recommended personal protective equipment (PPE) (see Attachment 6).
- Facilities should maintain a system for the identification of inmates, with COVID-19, who are at increased risk for severe illness (e.g., Older Adults, People with Certain Medical Conditions, Pregnant and Recently Pregnant People, People Who Use Drugs or Have Substance Use Disorder). If feasible, facilities should quarantine inmates in single cells and avoid cohorting in quarantine People Who Are at Increased Risk for Severe Illness (see also Evidence used to update the list of underlying medical conditions that increase a person's risk of severe illness from COVID-19). If cohorting is unavoidable, make all possible accommodations (e.g., intensify social distancing strategies), to reduce exposure risk and adverse health outcomes for inmates at increased risk for severe illness.

- If single cells for medical isolation (of those with suspected COVID-19) and quarantine (of close contacts) are limited, CDC recommends prioritizing the available housing in rank order as follows to reduce the risk of further SARS-CoV-2 transmission and adverse health outcomes:
  - Inmates with suspected COVID-19 who are at increased risk for severe illness from COVID-19.
  - Other inmates with suspected COVID-19.
  - Quarantined close contacts of someone with COVID-19 who are themselves at increased risk for severe illness from COVID-19.
- CDC recommends monitoring inmates in quarantine at least once per day for COVID-19 symptoms and temperature. If an inmate develops symptoms for SARS-CoV-2, the inmate should be considered a suspected COVID-19 case, given a mask (if not already wearing one), and moved to medical isolation immediately (individually, and separately from those with confirmed COVID-19 and others with suspected COVID-19) and further evaluated. If the inmate is tested and receives a positive result, the inmate can then be cohorted with other inmates with confirmed COVID-19. When an inmate who is part of a quarantined cohort becomes symptomatic:
  - If the inmate is tested for SARS-CoV-2 and receives a positive result, the 14-day quarantine clock for the remainder of the cohort must be reset to 0.
  - If the inmate is tested for SARS-CoV-2 and receives a negative result: the 14-day quarantine clock for this inmate and the remainder of the cohort does not need to be reset. The inmate can return from medical isolation to the quarantine cohort for the remainder of the quarantine period as the symptoms and diagnosis allow.
  - If the inmate is not tested for SARS-CoV-2, the 14-day quarantine clock for the remainder of the cohort must be reset to 0.
- Keep the inmate's movement outside the quarantine space to an absolute minimum.
  - Provide medical evaluation and care inside or near the quarantine space when possible.
  - Meals should be provided to quarantined inmates in the designated quarantine area. Disposable food service items can be placed in regular trash in the quarantine area. Non-disposable food service items should be handled with gloves and washed with hot water or in a dishwasher. Individuals handling food service items should perform hand hygiene after removing gloves and gowns.
  - Exclude the inmate from all group activities.
  - Laundry should be transported from the quarantine area to the laundering location in a bag liner that is either disposable or can be laundered. Individuals handling laundry from the quarantine area should wear a mask, disposable gloves, and a gown, discard after each use, and perform hand hygiene. Do not shake dirty laundry (to minimize the possibility of dispersing virus through the air). Laundry from quarantined inmates may be washed with other inmate laundry. Use the hottest appropriate water setting and dry items completely. Clean and disinfect clothes hampers in accordance with Element 3b.

- Ideally, the quarantine area should have a dedicated bathroom attached. If not, inmates must wear a mask (unless contraindicated) to go to the bathroom outside the room. When a dedicated bathroom is not feasible, do not reduce access to restroom or shower use as a result. Clean and disinfect areas used by quarantined inmates frequently on an ongoing basis during the quarantine period.

- Restrict quarantined inmates from leaving the facility (including transfers to other facilities) during the 14-day quarantine period, unless released from custody or a transfer is necessary for medical care, infection control, lack of quarantine space, or extenuating security concerns.
- If a quarantined inmate leaves the quarantine space for any reason, the inmate should wear a mask (unless contraindicated) as source control.
  - Quarantined inmates housed as a cohort should wear masks at all times, except when contraindicated or not practicable.
  - Quarantined inmates housed alone should wear masks whenever another individual enters the quarantine space, except when contraindicated or not practicable.
- Staff assignments to quarantine spaces should remain as consistent as possible. Staff assigned to quarantine posts should limit their movement to other parts of the facility as much as possible. If staff must serve multiple areas of the facility, ensure staff change PPE when leaving the quarantine space. If PPE supplies necessitate reuse, staff should move from areas of low to high exposure risk to prevent cross-contamination.
- Admission to and Discharge from Quarantine must be ordered by a Provider.
  - Inmates quarantined individually may be considered for release from quarantine restrictions if they have not developed COVID-19 symptoms and have not tested positive for SARS-CoV-2 for 14 days since their last exposure to someone who tested positive.
  - Consider testing inmates who are cohorted on quarantine when identified as close contacts of someone with suspected (not tested) or confirmed COVID-19 at the end of the 14-day quarantine period, before releasing the cohort from quarantine.
- If an inmate on quarantine status (not routine quarantine) due to exposure to suspected or confirmed COVID-19 is to be released from the facility before medically discharged from quarantine, notify the Hawaii Department of Health to provide direct linkage to community resources and release planning (e.g., transport, shelter, and medical care).
- If an inmate on quarantine status is scheduled to transfer to the Hawaii State Hospital or another correctional facility, hold the transfer until the inmate is cleared for transfer by the Medical Director.
- Inmates who are released while in quarantine should be provided education about the following:
  - Self-quarantine and stay home for 14 days* after last exposure.
  - Check temperature twice a day and watch for Symptoms of COVID-19.
  - Stay away from people, especially those who are higher risk for getting very sick from COVID-19.

*As an alternative to the 14-day quarantine period for inmates being released while on quarantine status, the quarantine period may be shortened to 10 days, ONLY if the following criteria are met:

- No clinical evidence of COVID-19 has been elicited by daily symptom monitoring during the quarantine period, up to the time quarantine is discontinued;
- Self-monitoring for symptoms of COVID-19 illness for a full 14 days after the last date of exposure;
- If symptoms develop within 14 days of the last exposure, the inmate should be tested for COVID-19 and self-isolate while awaiting results; **AND**
- The inmate is informed to strictly adhere to all recommended mitigation strategies, including:
  - Correct and consistent mask use
  - Physical distancing
  - Hand and cough hygiene
  - Avoiding crowds
  - Environmental cleaning and disinfection
  - Ensuring adequate indoor ventilation

13. Surveillance for New Cases

Inmates and staff should immediately report suspected cases of COVID-19 to the medical unit. Facilities should ensure that inmates receive medical evaluation and treatment at the first signs of COVID-19 symptoms. The initial medical evaluation should determine whether a symptomatic individual is at increased risk for severe illness from COVID-19.

- Daily screening of workline inmates, who provide services within the facility (e.g., kitchen, janitorial, laundry), is recommended to prevent infection in multiple locations.
- If individuals with COVID-19 have been identified among staff or inmates (excluding the introduction of a known COVID-19 positive inmate admission to the facility) in a facility, consider implementing regular symptom screening and temperature checks in housing areas that have not yet identified infections, until no additional infections have been identified in the facility for 14 days.
- In addition to routine intake quarantine (see Element #6) and routine transport quarantine (see Element #9), to the extent possible, implement and customize routine quarantine procedures for inmates who leave and/or return to the facility for other reasons (e.g., work furlough, weekend sentence, inmate workline, pre-release). As an example, implement routine work furlough quarantine (i.e., cohorting and restricting movement within the facility of all inmates, who leave and return to the facility while participating in work furlough). Inmates in routine work furlough quarantine should be housed separately from inmates who are quarantined due to contact with a suspected or confirmed COVID-19 case and the general inmate population.

14. Data Collection, Analysis, and Reporting

Implement methods for tracking information about inmates and employees with suspected and/or confirmed COVID-19.

- COVID-19 data assists public health professionals and health care providers monitor the spread and intensity of COVID-19 in our correctional system; supports an understanding of the illness, disease severity, and associated social disruptions; and informs the public health response to COVID-19. The following information should be tracked:
  - Facility: the specific correctional facility where the inmate is housed.
  - Tested: the number of inmates who have been administered a COVID-19 viral test and received results while incarcerated.
  - Results Pending: the number of inmates who have been administered a COVID-19 viral test and are waiting for results.
  - Refused Testing: the number of symptomatic inmates who refused COVID-19 viral testing.
  - Negative: the number of inmates who have been administered a COVID-19 test and have received a negative result from a COVID-19 viral test while incarcerated.
  - Inconclusive: the number of inmates who have been administered a COVID-19 test and have received an inconclusive result from a COVID-19 viral test while incarcerated.
  - Positive: the number of inmates who have been administered a COVID-19 test and have received a positive result from a laboratory confirmed COVID-19 PCR test while incarcerated.
  - Probable: the number of inmates who have been administered a COVID-19 test and have received a positive result from a COVID-19 antigen test, but do not confirm infection by taking a PCR test, while incarcerated.
  - Pre-Incarceration Positive: the number of inmates who received a positive result from a COVID-19 viral test prior to incarceration.
  - Number of Persons in Medical Isolation: the number of inmates who received a positive result from a COVID-19 viral test and are currently infectious and the number of inmates who are presenting with symptoms of COVID-19 and have been separated, in a single cell or by cohorting, from others who are not ill in order to prevent the spread of disease.
  - Number of Persons in Quarantine: the number of inmates who are asymptomatic close contacts of individuals with suspected or known COVID-19.
  - Hospitalization: the number of inmates with laboratory confirmed COVID-19 who are currently hospitalized.
  - Recovered: the number of inmates who received a positive COVID-19 viral test, but have been successfully treated and discharged from medical isolation by the Provider in accordance with CDC guidelines.
  - Court-Ordered Release: the number of inmates who were released by court order while on medical isolation status and followed by the DOH.

- Deaths: the number of inmates who received a positive COVID-19 viral test and was under the care of a Provider for COVID-19 at the time of death. This is provisional data that does not reflect the actual cause of death, which is based on the medical examiner report and autopsy.

- The Human Infection with 2019 Novel Coronavirus Person Under Investigation (PUI) and Case Report Form is submitted to the Hawaii Department of Health when COVID-19 viral testing is requested for inmates with symptoms of COVID-19. The form includes basic inmate medical and social history information, as well as information about clinical symptoms, pre-existing medical conditions, and respiratory diagnostic test results.
- To the extent permitted by Federal and State laws, facilities and programs should maintain a database on the number of employees who have tested positive for COVID-19, the number of employees who are recovered from COVID-19, and the number of employee deaths related to COVID-19. If a staff member has a confirmed SARS-CoV-2 infection, maintain the infected employee's confidentiality as required by the Americans with Disabilities Act.

15. Continuous Quality Improvement

The purpose of Continuous Quality Improvement (CQI) programs is to improve health care by identifying problems, implementing and monitoring corrective action, and studying the effectiveness of the corrective action. Periodically and at the conclusion of an outbreak, the facility should review the implementation of the COVID-19 Pandemic Response Plan in the context of identifying what has worked well and what areas require improvement. Findings from the facility CQI committee should be reported to the Division Administration for appropriate distribution to assist all correctional facilities. Members of the facility CQI committee should include the Warden and relevant Section Administrators.

COVID-19 Pandemic Response Plan Implementation Worksheet	
This MS Word® template worksheet is designed for facilities to operationalize the guidance in this COVID-19 Pandemic Response Plan. It should be adapted to the unique needs of your facility.	
Date Updated:	**Completed by:**
1. Administration/Coordination	
a. Identify members of the facility leadership team responsible for COVID-19 pandemic response planning and implementation, including roles and responsibilities: **b. How will facility administration regularly meet?**	
c. Who is responsible for monitoring COVID-19 updates from CDC and Hawaii Department of Health? **CDC Website:** https://www.cdc.gov/coronavirus/2019-ncov/index.html **Hawaii Department of Health Websites:** https://health.hawaii.gov/news/covid-19-updates/ https://health.hawaii.gov/docd/advisories/novel-coronavirus-2019/ https://health.hawaii.gov/docd/for-healthcare-providers/news-updates/	
2. Communication	
a. The mechanisms for regular updates (paper/electronic/telephonic) will be as follows: ▪ **Staff:** ▪ **Inmates:** ▪ **Families of inmates:** **Review recommendations for posting signage in the facility. What signage will be posted in the facility and where will the signage be posted?**	

b. The following staff are responsible for communicating with stakeholders:
c. Department of Health: Oahu (**Disease Reporting Line**): (808) 586-4586 Maui District Health Office: (808) 984-8213 Kauai District Health Office: (808) 241-3563 Big Island District Health Office (Hilo): (808) 933-0912 Big Island District Health Office (Kona): (808) 322-4877 After hours on Oahu: (808) 600-3625 After hours on neighbor islands: (800) 360-2575 (toll free) **Fax:** (808) 586-4595
d. Communicate with the Hawaii Department of Health and discuss guidance on management and COVID-19 testing of persons with respiratory illness. **Document date of communication and the plans discussed:**
e. Local community referral hospital: **Phone:**
3. General Prevention Measures
a. Good Health Habits: How will good health habits be promoted with your staff (e.g., posters, leadership emphasizing hand hygiene, educational video, email messages to staff)?

1) **Are there facilities for employees and visitors to wash hands when entering and leaving the facility? YES NO If no, what are the plans to address this issue?**

2) **Are there facilities for inmates to wash hands at intake? YES NO**
If no, what are the plans to address this issue?

3) **Are soap dispensers or hand soap available in all employee and inmate restrooms? YES NO**
What is the plan to ensure soap dispensers are refilled regularly?

4) **What is the plan to ensure inmates have an adequate supply of soap?**

5) **Are signs for hand hygiene and respiratory etiquette visibly posted at the entry, in modules, and other high traffic areas? YES NO**

6) **Are tissues available? YES NO If so, where?**

7) **Are no-touch trash receptacles available? YES NO**
If so, where?

b. Environmental Cleaning:
Review updated CDC recommendations regarding environmental cleaning. Note: common EPA-registered household disinfectants are considered effective. (*If necessary*) purchase EPA hospital-grade disinfectants from Schedule N: https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2. (Recommended products are both a surface cleaner and disinfectant with a 3-minute wet time or less.) What disinfectants will the facility use?

Identify "high-touch" surfaces in the facility (e.g., doorknobs, handrails, keys, telephones):

The following plan will be implemented to increase the frequency and the extent of cleaning and disinfection of high-touch surfaces in this facility:

c. Social Distancing Measures: What administrative measures will your facility implement to increase social distancing (Review across all Sections in the facility)?

1)

2)

3)

4)

5)

6)

7)

8)

9)

In what areas of the facility do staff interact or come in close contact with one another (e.g., break rooms, locker rooms, shared offices)?

What precautions are you taking to prevent transmission between staff members in these spaces?

d. Encourage the Use of Masks and Other No-Contact Barriers:

Will the facility distribute masks to staff and inmates? YES NO

What is the facility plan for inmate encounters using no-contact barriers?

e. Employees Stay Home When Sick: Does communication with employees include the message that they should stay home when sick or under quarantine? YES NO

Sick employees should be advised to follow CDC guidance on What to do if you are Sick

If NO, what corrective action will be implemented?

f. COVID-19 Vaccination: Is there a protocol for obtaining and administering COVID-19 vaccines? YES NO

If yes, what is the procedure for obtaining COVID-19 vaccines?

If yes, what plans are there to continue offering COVID-19 vaccination to inmates who have not been vaccinated?

Have health care staff received training on how to respond to inmate questions about COVID-19 vaccines?
YES NO

g. Influenza Vaccination: Is there flu vaccine in stock? YES NO

If yes, number of doses?

If yes, what plans are there to continue offering vaccination to health care staff and inmates who have not been vaccinated?

h. Infection Prevention and Control Guidance When Screening: Have staff who conduct screening of employees, visitors, vendors, volunteers, and new intakes received education on the infection prevention and control guidance? YES NO

If no, what corrective action be taken?

i. Control Strategies for Aerosol Generating Procedures:

Did medical staff implement control strategies for aerosol generating procedures involving diagnostics, CPAP/BiPAP use, pulmonary function/peak flow tests, and nebulizer treatments?
YES NO

If NO, what corrective actions are being implemented?

Did dental staff implement control strategies for aerosol generating procedures in accordance with the CDC Interim Infection Prevention and Control Guidance for Dental Settings During the COVID-19 Response and guidance from the Hawaii Board of Dentistry?
YES NO

If NO, what corrective actions are being implemented?

4. Visitors / Vendors / Volunteers

What changes in procedures/polices are being instituted in response to COVID-19 for:

a. Visitors:

b. Volunteers:

c. Vendors:

d. Attorneys:

What signage or methods are being used to communicate with visitors?

Is the facility prepared to conduct screening for visitors/vendors/volunteers? YES NO

If yes, who will conduct the screening?

5. Employee Screening

Do you have an infrared no-touch thermometer for employee screening? YES NO

If NO, what are your plans for acquiring an infrared no-touch thermometer?

When did your facility implement employee screening?

The following system will be utilized for employees to report illness/exposures:

The following system will be used to track employee illness/exposures:

6. New Intake Screening

It is recommended that new arrivals be isolated from rest of population until screening is performed. New intakes should be screened with temperature and questionnaire.

Where will screening occur?

Who will conduct screening?

What other screening logistics are being considered?

7. Initial Management and Testing of SARS-CoV-2

It is recommended that individuals with symptoms be immediately issued a mask and be placed in a separate room with a toilet and sink.

What separate room will be used for this purpose?

Do you have capacity in this facility to perform testing of SARS-CoV-2? YES NO
If yes, what are the plans to ensure competency in nasopharyngeal swabbing?

What are current recommendations from your Medical Director and the Hawaii Department of Health regarding COVID-19 testing?

Review CDC recommendation for collection of clinical specimens. Do you have needed supplies for testing? YES NO

If NO, what are your plans to obtain the supplies?

Planning for how the facility will modify operations when implementing broad-based testing for SARS-CoV-2.

Will specific housing units or areas be designated for inmates who test positive? YES NO

How will the facility manage those who decline testing?

If testing reveals that more inmates are positive than negative, will those who test negative be reassigned to different housing (rather than reassigning those who test positive)? YES NO

If yes, how will the facility mitigate further transmission within the facility?

How will housing areas be systematically and thoroughly cleaned and disinfected if large numbers of positive inmates are identified and housing units are rearranged?

How will the facility manage the logistics of moving large numbers of inmates into different housing arrangements (e.g., where will inmates go while the housing units are being cleaned and disinfected, and how will positive and negative inmates be separated during this time)?

8. Personal Protective Equipment

Date: **What is the current inventory of the following?**

Surgical Masks:

N-95 respirators:

Gowns (disposable):

Gowns (washable):

Eye Protection- Goggles:

Eye Protection—Disposable face shields:

What is your plan for securing and maintaining an adequate supply of PPE?

If respirators are available, but in limited supply, what activities will they be prioritized for?

What is your plan for fit-testing adult correctional officers?

What is your plan for fit-testing health care workers?

What is your plan for fit-testing inmate workline?

How does the facility plan to train adult correctional officers in donning and doffing of PPE?

Who will conduct the training?

Who will organize the training?

When will the training occur?

How does the facility plan to train Health Care Workers in donning and doffing of PPE?

How does the facility plan to train inmate workline in donning and doffing of PPE?

Review Table 3 (COVID-19 Personal Protective Equipment Recommendations) and the CDC Strategies to Optimize the Supply of PPE and Equipment. **What strategies are being implemented to optimize the supply of PPE and equipment?**

9. Transport

What is your plan for training transport staff on procedures fortransport?

10. Medical Isolation / Cohorting (*Symptomatic Inmates*)
What is your capacity for medically isolating inmates with suspected COVID-19 in single cells with a toilet? **Where will medical isolation cells for suspected COVID-19 be located?** **What is your capacity for cohorting inmates in cells, quads, modules, or dorms, with toilets/sinks?** **What areas of the facility have been designated for medical isolation of confirmed COVID-19 in cohorts?** **What is your plan for designating and training officers assigned to medical isolation cells, quads, modules, or dorms on isolation room procedures?** **Is it feasible to designate specific security staff to only monitor medically isolated inmates to minimize the potential for exposure among staff? YES NO** **If YES, how will staff be selected for this duty?** **Review recommendations for laundry and food service. What are your plans for educating staff and inmate workers on the laundry and food service recommendations?** **Review recommendations for cleaning areas where COVID-19 cases spent time. What are your plans for training staff and inmate workers on the cleaning recommendations?**

11. Care for the Sick
Do you have an adequate supply of Oxygen and medications for supportive care of a respiratory illness? **What is your facility plan for monitoring ill inmates?**
12. Quarantine (*Asymptomatic Exposed Inmates*)
What cells, quads, modules, and dorms could be used for individual quarantine? **What cells, quads, modules, and dorms could be used for group quarantine?** **How do you plan to monitor inmates under quarantine?** **What is your plan for supplying masks needed for an entire housing unit of inmates for a period of 14 days?** **What is your plan/ability to provide single cells for exposed persons who have risks for complications (e.g., over age 60 or with medical risk factors)?**

13. Surveillance for New Cases
What is the facility plan for notifying the medical unit of suspected COVID-19 cases by inmates and staff? **What is the facility procedure for daily screening of workline inmates?**
14. Data Collection, Analysis, and Reporting
Who is responsible for collecting and reporting data on employees with suspected/confirmed COVID-19? **How will the employee information be communicated to the data collector?** **Who is responsible for collecting and reporting data on inmates with suspected/confirmed COVID-19?** Daniel Kinikini, CRS, and Toni Schwartz, PIO, collect and report on data, respectively. **How will the inmate information be communicated to the data collector?** Facility nursing will report instances of COVID-19 testing, requiring medical isolation and quarantine as a Priority I Incident.
15. Continuous Quality Improvement
Who are the members of the facility CQI committee for COVID-19? **Who will be responsible for communicating the results of the reviews to the Division Administrators for appropriate distribution to other facilities?**

Attachment 1A. COVID-19 Visitor/Vendor/Volunteer Screening Tool A

DEPARTMENT OF PUBLIC SAFETY
CORONAVIRUS DISEASE 2019 (COVID-19)
VISITOR/VENDOR/VOLUNTEER SCREENING TOOL

SECTION A (TO BE COMPLETED BY VISITOR/VENDOR/VOLUNTEER)

Please complete the following:	
Date of Requested Entrance	
Name	
1. Please answer the following questions:	
☐ Yes ☐ No	In the past 10 days, have you tested positive for COVID-19?
☐ Yes ☐ No	In the past 14 days, have you traveled off-island?
☐ Yes ☐ No	In the past 14 days, have you had contact with a person suspected or known to be infected with COVID-19?
2. Today or in the past 14 days, have you had any of the following symptoms?	
☐ Yes ☐ No	Fever, Felt Feverish, or Chills
☐ Yes ☐ No	Cough
☐ Yes ☐ No	Shortness of Breath or Difficulty Breathing
☐ Yes ☐ No	Fatigue
☐ Yes ☐ No	Muscle or Body Aches
☐ Yes ☐ No	Headache
☐ Yes ☐ No	New Loss of Taste or Smell
☐ Yes ☐ No	Sore Throat
☐ Yes ☐ No	Congestion or Runny Nose
☐ Yes ☐ No	Nausea or Vomiting
☐ Yes ☐ No	Diarrhea or Loose Stool
3. Temperature	
☐ Yes ☐ No	Can staff take your temperature?

SECTION B (TO BE COMPLETED BY STAFF)

4. Take Temperature	
☐ Yes ☐ No	Is the temperature of the visitor/vendor/volunteer 100.0°F or above?
5. Clearance	
☐ Yes ☐ No	Is the visitor/vendor/volunteer clear for purpose of this screening to enter the facility?

Staff Name: _____

Staff Title: _____

PSD 0999AX (11/20) CONFIDENTIAL

Attachment 1B. COVID-19 Visitor/Vendor/Volunteer Screening Tool B

DEPARTMENT OF PUBLIC SAFETY
CORONAVIRUS DISEASE 2019 (COVID-19)
VISITOR/VENDOR/VOLUNTEER SCREENING TOOL

SECTION A (TO BE COMPLETED BY VISITOR/VENDOR/VOLUNTEER)

Please complete the following:	
Date of Requested Entrance	
Name	
1. Please answer the following questions:	
☐ Yes ☐ No	In the past 10 days, have you tested positive for COVID-19?
☐ Yes ☐ No	In the past 14 days, have you traveled outside Hawaii?
☐ Yes ☐ No	In the past 14 days, have you had contact with a person suspected or known to be infected with COVID-19?
2. Today or in the past 14 days, have you had any of the following symptoms?	
☐ Yes ☐ No	Fever, Felt Feverish, or Chills
☐ Yes ☐ No	Cough
☐ Yes ☐ No	Shortness of Breath or Difficulty Breathing
☐ Yes ☐ No	Fatigue
☐ Yes ☐ No	Muscle or Body Aches
☐ Yes ☐ No	Headache
☐ Yes ☐ No	New Loss of Taste or Smell
☐ Yes ☐ No	Sore Throat
☐ Yes ☐ No	Congestion or Runny Nose
☐ Yes ☐ No	Nausea or Vomiting
☐ Yes ☐ No	Diarrhea or Loose Stool
3. Temperature	
☐ Yes ☐ No	Can staff take your temperature?

SECTION B (TO BE COMPLETED BY STAFF)

4. Take Temperature	
☐ Yes ☐ No	Is the temperature of the visitor/vendor/volunteer 100.0°F or above?
5. Clearance	
☐ Yes ☐ No	Is the visitor/vendor/volunteer clear for purpose of this screening to enter the facility?

Staff Name: _____

Staff Title: _____

PSD 0999BX (11/20) CONFIDENTIAL

Attachment 2A. COVID-19 Employee Screening Tool A

DEPARTMENT OF PUBLIC SAFETY
CORONAVIRUS DISEASE 2019 (COVID-19)
EMPLOYEE SCREENING TOOL

SECTION A (TO BE COMPLETED BY EMPLOYEE)

Please complete the following:	
Date	
Employee Name	
1. Please answer the following questions:	
☐ Yes ☐ No	In the past 10 days, have you tested positive for COVID-19?
☐ Yes ☐ No	In the past 14 days, have you traveled off-island?
☐ Yes ☐ No	In the past 14 days, have you had contact with a person suspected or known to be infected with COVID-19, while not wearing recommended PPE?
2. Today or in the past 14 days, have you had any of the following symptoms?	
☐ Yes ☐ No	Fever, Felt Feverish, or Chills
☐ Yes ☐ No	Cough
☐ Yes ☐ No	Shortness of Breath or Difficulty Breathing
☐ Yes ☐ No	Fatigue
☐ Yes ☐ No	Muscle or Body Aches
☐ Yes ☐ No	Headache
☐ Yes ☐ No	New Loss of Taste or Smell
☐ Yes ☐ No	Sore Throat
☐ Yes ☐ No	Congestion or Runny Nose
☐ Yes ☐ No	Nausea or Vomiting
☐ Yes ☐ No	Diarrhea or Loose Stool
3. Temperature	
☐ Yes ☐ No	Can the screener take your temperature?

SECTION B (TO BE COMPLETED BY SCREENER)

4. Take Temperature	
☐ Yes ☐ No	Is the temperature of the employee 100.0°F or above?
5. Clearance	
☐ Yes ☐ No	Is the employee clear for purpose of this screening to enter the facility?

Screener Name: _____

Screener Title: _____

PSD 0998AX (11/20) CONFIDENTIAL

Attachment 2B. COVID-19 Employee Screening Tool B

DEPARTMENT OF PUBLIC SAFETY
CORONAVIRUS DISEASE 2019 (COVID-19)
EMPLOYEE SCREENING TOOL

SECTION A (TO BE COMPLETED BY EMPLOYEE)

Please complete the following:	
Date	
Employee Name	
1. Please answer the following questions:	
☐ Yes ☐ No	In the past 10 days, have you tested positive for COVID-19?
☐ Yes ☐ No	In the past 14 days, have you traveled outside Hawaii?
☐ Yes ☐ No	In the past 14 days, have you had contact with a person suspected or known to be infected with COVID-19, while not wearing recommended PPE?
2. Today or in the past 14 days, have you had any of the following symptoms?	
☐ Yes ☐ No	Fever, Felt Feverish, or Chills
☐ Yes ☐ No	Cough
☐ Yes ☐ No	Shortness of Breath or Difficulty Breathing
☐ Yes ☐ No	Fatigue
☐ Yes ☐ No	Muscle or Body Aches
☐ Yes ☐ No	Headache
☐ Yes ☐ No	New Loss of Taste or Smell
☐ Yes ☐ No	Sore Throat
☐ Yes ☐ No	Congestion or Runny Nose
☐ Yes ☐ No	Nausea or Vomiting
☐ Yes ☐ No	Diarrhea or Loose Stool
3. Temperature	
☐ Yes ☐ No	Can the screener take your temperature?

SECTION B (TO BE COMPLETED BY SCREENER)

4. Take Temperature	
☐ Yes ☐ No	Is the temperature of the employee 100.0°F or above?
5. Clearance	
☐ Yes ☐ No	Is the employee clear for purpose of this screening to enter the facility?

Screener Name: _____

Screener Title: _____

PSD 0998BX (11/20) CONFIDENTIAL

Attachment 3. CDC Contact Precautions Sign

Attachment 4. CDC Droplet Precautions Sign

Attachment 5. Isolation Room Precautions Sign

Respiratory Infection Isolation Room Precautions

PRECAUCIONES de sala de aislamiento de infección respiratoria

TO PREVENT THE SPREAD OF INFECTION,

ANYONE ENTERING THIS ROOM SHOULD USE:

Para prevenir el esparcimiento do infecciones,
todas las peronas que entren e esta habitacion tienen que:

	**HAND HYGIENE** *Hygiene De Las Manos*
	**Face Mask or N-95 Respirator** *Mascara Facial o Respirador N95*
	**Gloves** *Guantes*
	**GOWN** *Bata*
	**Eye Protection** *Protección para los ojos*
	**Ensure that the door to this room remains closed <u>at all times</u>.** *Asegurese de mantener la puerta de esta habitacion carrada <u>todo el tiempo</u>.*

Attachment 6. Quarantine Room Precautions Sign

Quarantine Room Precautions

PRECAUCIONES de Sala de Cuarentena

TO PREVENT THE SPREAD OF INFECTION,

ANYONE ENTERING THIS ROOM SHOULD USE:

Para prevenir el esparcimiento do infecciones,

todas las peronas que entren e esta habitacion tienen que:

	**HAND HYGIENE** ***Hygiene De Las Manos***
	**Face Mask** ***Mascara facial***
	**Eye Protection** ***Protección para los ojos si contacto cercano***
	**Gloves** ***Guantes***
	Ensure that the door to this room remains closed <u>at all times</u>. ***Asegurese de mantener la puerta de esta habitacion carrada <u>todo el tiempo</u>.***

Attachment 7. COVID-19 Re-entry Information Handout

DEPARTMENT OF PUBLIC SAFETY

COVID-19 RE-ENTRY INFORMATION

COVID-19 INFO:
CALL 2-1-1
TEXT 8??-???-????
CHAT
EMAIL
hawaiicovid19.com

Coronavirus Disease 2019 (COVID-19) is a respiratory illness that can spread from person-to-person. Symptoms of the disease may include fever, cough, and/or shortness of breath. Severe cases can result in hospitalization and death. Residents of Hawaii are advised to take a few simple precautions to help reduce their risk of exposure.

HOW TO PROTECT YOURSELF & OTHERS

Avoiding crowds and other people's personal space helps to curb the spread of the virus. **Social Distancing** or keeping at least six feet away from other people will also reduce your chances of catching COVID-19. Examples general prevention measures:

- Avoid handshaking, hugging, and other intimate types of greetings
- Wash your hands often with soap and water for at least 20 seconds after you have been in a public place, or after blowing your nose, coughing, or sneezing
- Avoid touching your eyes, nose, and mouth with unwashed hands
- Clean and disinfect frequently touched objects and surfaces
- Avoid groups larger than 10 people, especially in poorly ventilated spaces
- Stay at home as much as possible
- Wear a cloth face mask or equivalent face covering

SELF-QUARANTINE

People who have been exposed to the new coronavirus and who are at risk for coming down with COVID-19 should **self-quarantine**. Health experts recommend a self-quarantine period of 14 days. Two weeks provides enough time for people to know whether they will become ill and be contagious to other people. Self-quarantine involves:

- Staying at home
- Not having visitors
- Practicing social distancing with other people in your household
- Standard hygiene practice and frequent hand washing
- Not sharing things like towels and dining ware

RESOURCES AND LINKS

Below are COVID 19 hotline numbers and web links for more information:

- **Hawaii Department of Health**
  - 2-1-1
    https://www.hawaiicovid19.com/ or
    https://www.health.hawaii.gov/coronavirusdisease2019/
- **Centers for Disease Control and Prevention**
  - 1-800-232-4636
    https://www.cdc.gov/coronavirus/2019-ncov/index.html

Attachment 8. Control Strategies for Aerosol Generating Procedures

General Strategies to Reduce Risk with Aerosol Generating Procedures:

1. Examine whether the procedure is medically necessary, identify viable effective alternatives, and consider temporarily discontinuing non-essential use during the COVID-19 pandemic.
2. If aerosol generating procedures are deemed medically necessary, minimize the risk by:
    a. Limiting staff involved in the procedure
    b. Recommended PPE: N95 respirator, face shield, gloves and gown.
    c. Perform in airborne infection isolation (AII) room or single room with solid walls and doors.
    d. Thoroughly disinfect the room after use.

Procedure	Recommendations
Diagnostics (e.g., COVID-19, Influenza)	**Nasopharyngeal and oropharyngeal swabs** should be performed in a room with a door that closes. PPE: N95 respirator, gown, gloves, eye protection
Dental	**Dental Health Professionals adhere to the CDC Interim Infection Prevention and Control Guidance for Dental Settings During the COVID-19 Response** and guidance from the Hawaii Board of Dentistry**.** PPE: N95 respirator, gown, gloves, eye protection
CPAP/BiPAP	**Providers review patients with sleep apnea on CPAP/BiPAP:** ▪ For most patients on CPAP the short-term discontinuation of CPAP is less risky than the potential for aerosolized virus spread with CPAP use during pandemic. ▪ For patients on BiPAP/CPAP with severe sleep apnea and comorbidities (such as significant cardiomyopathy with history of arrhythmias) for whom short-term discontinuation of BiPAP/CPAP is not considered safe, single cell housing (with solid door) should be sought. ▪ COVID-19 can live on surfaces so frequent cleaning of CPAP equipment being used is encouraged during the pandemic
PFTs/Peak Flow Meters	It is recommended that pulmonary function tests and peak flow measurements be postponed due to COVID-19 pandemic.
Nebulizer Treatments	**Avoid nebulizer use by converting to metered dose inhaler (MDI) if possible** ▪ Use MDI with spacer, if possible ▪ Consider increasing puffs per sitting and more frequent use, if clinically indicated ▪ Some medications are available as dry powder inhaler ▪ National supply issues have been reported for some MDIs; consult with pharmacist as needed **If must use nebulizer:** ▪ Use in single room with closed door ▪ Limit staff and staff present use N95 respirator, gown, gloves, eye protection ▪ Disinfect room and equipment after treatment
CPR	**CPR is performed in accordance with American Heart Association guidelines.** Modifications include: ▪ Limit number of people in room to essential (no more than 3) ▪ Put on appropriate PPE before entering the scene: N95 respirator, gown, gloves, eye protection ▪ Use of bag-mask ventilation over mouth-mask/face shield preferred

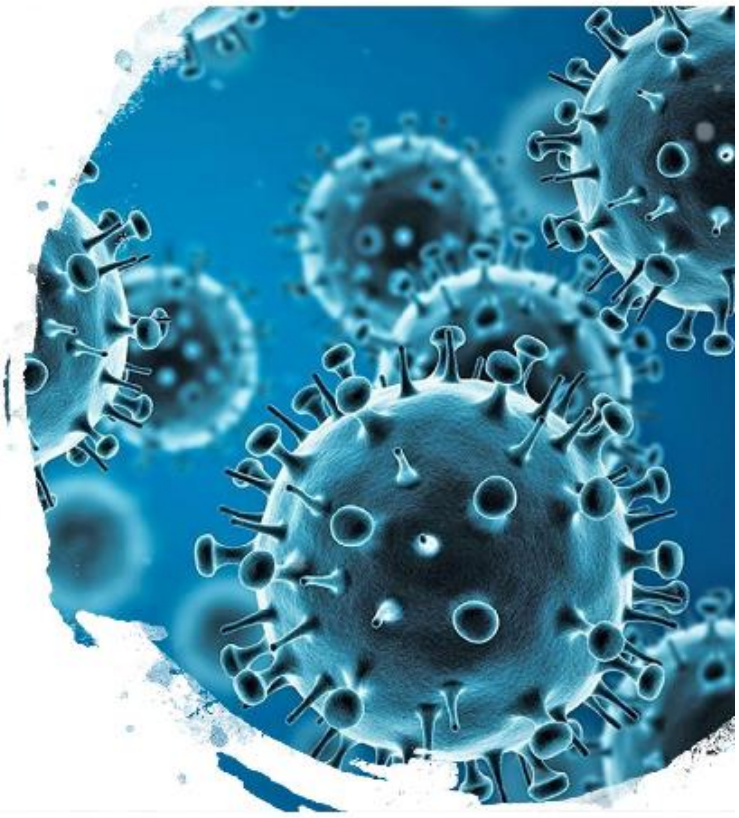
Adapted from: VitalCore Health Strategies and California Department of Corrections Division of Health Care Services Memorandum: Aerosol Generating Procedures, April 8, 2020.

Attachment 9. HCD Seasonal Influenza Campaign

Da FLU ends with "U"

Get Your Free Flu Shot Today
and
Get 1 FUTURE COPAY Credit

Copay credit can only be used for one (1) future visit.
One (1) per person per year.
Expires one (1) year from the date of your flu shot.
Non-transferrable (no trading). No cash value.



Appendix 1. CDC Definitions of Commonly Used Terms

Close contact of someone with COVID-19 – Someone who was within 6 feet of an infected person for a cumulative total of 15 minutes or more over a 24-hour period* starting from 2 days before illness onset (or, for asymptomatic patients, 2 days prior to test specimen collection) until the time the person is isolated.

** Individual exposures added together over a 24-hour period (e.g., three 5-minute exposures for a total of 15 minutes). Data are limited, making it difficult to precisely define "close contact;" however, 15 cumulative minutes of exposure at a distance of 6 feet or less can be used as an operational definition for contact investigation. Factors to consider when defining close contact include proximity (closer distance likely increases exposure risk), the duration of exposure (longer exposure time likely increases exposure risk), whether the infected individual has symptoms (the period around onset of symptoms is associated with the highest levels of viral shedding), if the infected person was likely to generate respiratory aerosols (e.g., was coughing, singing, shouting), and other environmental factors (crowding, adequacy of ventilation, whether exposure was indoors or outdoors). If the employee has not received training on proper selection and use of respiratory PPE, such as an N95, the determination of close contact should generally be made irrespective of whether the contact was wearing respiratory PPE. At this time, differential determination of close contact for those using fabric face coverings is not recommended.*

Cohorting – The practice of isolating multiple individuals with laboratory-confirmed COVID-19 together or quarantining close contacts of an infected person together as a group due to a limited number of individual cells. While cohorting those with confirmed COVID-19 is acceptable, cohorting individuals with suspected COVID-19 is not recommended due to high risk of transmission from infected to uninfected individuals.

Community transmission of SARS-CoV-2 – When individuals are exposed to the virus through contact with someone in their local community, rather than through travel to an affected location. When community transmission is occurring in a particular area, correctional facilities and centers are more likely to start seeing infections inside their walls.

Confirmed vs. suspected COVID-19 – A person has **confirmed COVID-19** when they have received a positive result from a COVID-19 viral test (i.e., RT-PCR) but they may or may not have symptoms. A person has **suspected COVID-19** if they show symptoms of COVID-19 but either have not been tested via a viral PCR test or are awaiting test results. If their test result is positive, suspected COVID-19 is reclassified as confirmed COVID-19.

Masks – Masks cover the nose and mouth and are intended to help prevent people who have the virus from transmitting it to others, even if they do not have symptoms. CDC recommends wearing cloth masks in public settings where social distancing measures are difficult to maintain. Masks are recommended as a simple barrier to help prevent respiratory droplets from traveling into the air and onto other people when the person wearing the mask coughs, sneezes, talks, or raises their voice. This is called **source control**. If everyone wears a mask in congregate settings, the risk of exposure to SARS-CoV-2 can be reduced. Anyone who has trouble breathing or is unconscious, incapacitated, younger than 2 years of age or otherwise unable to remove the mask without assistance should not wear a mask (for more details see How to Wear Masks). **CDC does not recommend use of masks for source control if the mask has an exhalation valve or vent).** Individuals working under conditions that require PPE should not use a cloth mask when a surgical mask or N95 respirator is indicated. Surgical masks and N95 respirators should be reserved for situations where the wearer needs PPE. Detailed recommendations for wearing a mask can be found here.

Medical isolation – Separating someone with confirmed or suspected COVID-19 infection to prevent their contact with others to reduce the risk of transmission. Medical isolation ends when the individual meets pre-established criteria for release from isolation, in consultation with clinical providers and public health officials. In this context, isolation does NOT refer to punitive isolation for behavioral infractions within the custodial setting. Staff are encouraged to use the term "medical isolation" to avoid confusion, and should ensure that the conditions in medical isolation housing are distinct from those in disciplinary segregation.

Quarantine – The practice of separating individuals who have had close contact with someone with COVID-19 to determine whether they develop symptoms or test positive for the disease. Quarantine reduces the risk of transmission if an individual is later found to have COVID-19. Quarantine for COVID-19 should last for 14 days after the exposure has ended. Ideally, each quarantined individual should be housed in a single cell with solid walls and a solid door that closes. If symptoms develop during the 14-day period, and/or a quarantined individual receives a positive viral test result for SARS-CoV-2, the individual should be placed under medical isolation and evaluated by a healthcare professional. If symptoms do not develop during the 14-day period and the individual does not receive a positive viral test result for SARS-CoV-2, quarantine restrictions can be lifted. (NOTE: Some facilities may also choose to implement a "routine intake quarantine," in which individuals newly incarcerated/detained are housed separately or as a group for 14 days before being integrated into general housing. This type of quarantine is conducted to prevent introduction of SARS-CoV-2 from incoming individuals whose exposure status is unknown, rather than in response to a known exposure to someone infected with SARS-CoV-2.)

NOTE: According to the CDC, "The best way to protect incarcerated/detained persons, staff, and visitors is to quarantine for 14 days." As an alternative to the 14-day quarantine period for identified close contacts who do not reside in a correctional facility, HDOH adopted the CDC option to shorten the quarantine period to 10 days, ONLY if the following criteria are met:

- No clinical evidence of COVID-19 has been elicited by daily symptom monitoring during the quarantine period, up to the time quarantine is discontinued;
- Self-monitoring for symptoms of COVID-19 illness for a full 14 days after the last date of exposure;
- Close contacts who develop symptoms within 14 days of the last exposure should be tested for COVID-19 and self-isolate while awaiting results; **AND**
- Close contacts are informed to strictly adhere to all recommended mitigation strategies, including:
  - Correct and consistent mask use
  - Physical distancing
  - Hand and cough hygiene
  - Avoiding crowds
  - Environmental cleaning and disinfection
  - Ensuring adequate indoor ventilation

Social distancing – The practice of increasing the space between individuals and decreasing their frequency of contact to reduce the risk of spreading a disease (ideally to maintain at least 6 feet of physical distance between all individuals, even those who are asymptomatic). Social distancing strategies can be applied on an individual level (e.g., avoiding physical contact), a group level (e.g., canceling group activities where individuals would be in close contact), and an operational level (e.g., rearranging chairs in the dining hall to increase distance between them). Social distancing is vital for the prevention of respiratory diseases such as COVID-19, because people who have been infected with SARS-CoV-2 but do not have symptoms can still spread the infection. Additional information about social distancing, including information on its use to reduce the spread of other viral illnesses, is available in this CDC publication.